ANALYZING THE ISSUES

CRITICAL PERSPECTIVES ON ASSISTED SUICIDE

Edited by Jennifer Peters

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CONTENTS

INTRODUCTION

CHAPTER 1

WHAT THE EXPERTS SAY

CHAPTER 2

WHAT THE GOVERNMENT AND POLITICIANS SAY

CHAPTER 3

WHAT THE COURTS SAY

CHAPTER 4

WHAT ADVOCATES SAY

CHAPTER 5

WHAT THE MEDIA SAY

CHAPTER 6

WHAT ORDINARY PEOPLE SAY

CONCLUSION

BIBLIOGRAPHY

CHAPTER NOTES

GLOSSARY
FURTHER READING
INDEX
ABOUT THE EDITOR

INTRODUCTION

For years, there has been an ongoing argument over assisted suicide, the practice of having physicians aid patients in dying at a time of their choosing. In the 1990s, Dr. Jack Kevorkian became the most famous supporter of physician-assisted suicide after he was tried and convicted for his role in helping numerous people commit suicide.

While Kevorkian brought the issue into the spotlight, the debate around the practice of doctor-assisted suicide has been raging for decades. Those who support it are considered to be part of a right-to-die movement, while those opposed preach a right-to-life agenda. And each side has numerous caveats in their arguments. Some who support the right to die only support it if a person is terminally ill and will at some point in the immediate future die of natural causes. Some feel that there should be psychological evaluation and various other steps taken before a patient can be put to death, as they don't want people to take advantage of the system. Still others want to limit the practice by age or type of illness or to those for whom there are no treatments to improve the patient's quality of life leading up to the time of death.

On the other end of the spectrum, there are those who would allow anyone of legal adult age to choose to die when

and how they wish, regardless of illness or impending death.

You'll look at stories about places where the right to die is considered a legal and moral right, and places where suicide is a crime. Both sides have thought through the issue and spent hours and years determining what they believe the right choice is for the citizens living under their jurisdiction. And each side has faced battles because of the choice they've made.

In the coming chapters, you'll explore the issue from all sides, looking at what doctors, advocacy groups, judges, and lawmakers have to say about the right to die. You'll be asked to consider the stories of patients who sought the right to die, as well as the stories of the families and friends left behind. Each position will be loaded with ethical, religious, moral, and legal concerns, and you'll have to decide which, if any, of those concerns should be taken into account when a person is seeking the chance to commit medical suicide.

The issue is more complicated than simply being in favor of the right to life or the right to die, and you'll see that as you go through the stories that support both sides of the argument. As you do, consider how you would respond to the questions raised by each article, and think about what your answers would mean for those who seek permission to end their lives on their terms.

CHAPTER 1

WHAT THE EXPERTS SAY

The right to die has long been debated in the academic realm. Researchers, doctors, professors, ethicists—they all have an opinion on whether people should have the right to choose when and how they die and whether the medical establishment can or should be tasked with helping them achieve their death goals. In this chapter, you'll see what those in the medical community have to say about physician-assisted suicide and what their counterparts in the philosophical fields think. As you read the following articles, consider how these professionals came to their opinions and whether you think their decisions are based on their experience or their personal feelings.

"WHY AUSTRALIA HESITATES TO LEGALISE EUTHANASIA," BY ANDREW MCGEE, FROM *THE CONVERSATION,* NOVEMBER 11, 2015

The Australian public supports legalising euthanasia and bills are introduced into state parliaments every year. Yet Australian governments continue to resist legalising euthanasia or its cousin, assisted suicide.

Some of the concerns at the heart of this resistance can be addressed with carefully drafted legislation. But others, such as how we value life, remain key challenges for policymakers.

VULNERABILITY CONCERNS

When euthanasia (I use the term here to include assisted suicide) is debated, both sides tend to raise "slippery slope" and vulnerability concerns.

Opponents of legalisation say: once we take the significant step of allowing doctors to kill patients (or to help patients end their lives) in narrowly defined circumstances, there will be pressure to increase the range of circumstances with

amending legislation. And it's easier to *amend* existing legislation than enact it in the first place (the slippery slope concern).

Or, patients who do not really want to end their lives might feel they are a burden and so feel a subtle pressure, real or imagined, to end their lives when this is not what they want (the vulnerability concern).

Proponents – such as broadcaster and television producer Andrew Denton – generally respond by claiming there is no evidence of either concern being realised in places where euthanasia is lawful.

The issue about evidence is controversial, and so the debate about these two well-known concerns goes on. But it seems that both concerns can be alleviated.

The vulnerability concern, in particular, can largely be dealt with by providing safeguards in legislation. We can require qualified, independent third parties to check whether the decision is genuinely voluntary, rather than coerced, and provide a minimum period of time during which the patient's decision must be an unwavering one.

Although there is scepticism about whether these safeguards would always be complied with or effective, this is no less a concern with the status quo, such as with decisions to withdraw life-sustaining measures or give pain relief which may hasten death. These are just as susceptible to abuse as euthanasia, but are already lawful.

So why is there an abiding resistance to euthanasia, and is there anything that can be done about it?

QUESTION OF ACCESS

The main difficulty in combating resistance to euthanasia has been deciding who should have access: should it be restricted to the terminally ill?

Should it extend to people who have an unbearable physical condition which does not make them terminally ill?

Or should it even extend to people who aren't physically ill at all, but are experiencing unbearable mental suffering?

Andrew Denton suggests it should not be restricted but based simply on "unbearable suffering", as it is in Belgium. This means that it could extend to people who have no physical ailment.

A case discussed in a recent episode of the SBS program Dateline illustrates just what a dilemma the access question is. The program presented the case of a woman in Belgium, Simona de Moor, 85. She wanted to take the opportunity to end her life under what the program describes as "the most liberal euthanasia laws in the world".

Simona was not terminally ill. But under Belgian law it is not necessary to be terminally ill for euthanasia or assisted suicide. It is sufficient to be experiencing unbearable mental suffering that cannot be alleviated.

Someone who is depressed, where that depression is not responsive to attempts at alleviation, can ask for euthanasia or assisted suicide, provided the

request is voluntary and well thought through (it doesn't impair capacity), and the desire to die is unwavering.

In the program, Simona tells viewers she lost the will to live after her daughter, with whom she was very close, died – just three months before the day Simona would herself choose to die by lethal poisoning.

One worry here is that Simona's judgement is clearly being made while she is still grieving for her daughter.

However, we can draft legislation to ensure that Australians would not be able to make such a choice so soon after the loss of a loved one. So this concern is not fatal to the case for euthanasia.

The deeper worry is this: if we allow people with no terminal illness to have help to end their lives, what avenues for survival and recovery are closed off?

VALUE OF HUMAN LIFE

Legalisation this broad inevitably brings about a shift in how we think about our lives. In Belgium, someone who is depressed but otherwise well, such as Simona, is able to enter a train of thought that is allowed to gather momentum because euthanasia is a genuine option.

Alternative ways of thinking about her situation become unavailable. If you keep thinking about ending your life, just as if you keep thinking about failure, it can become a self-fulfilling prophecy. Other possibilities are not even entertained.

This is what opponents worry about when they say euthanasia could "erode" the value of human life. This is one horn of the dilemma about euthanasia for patients who are not terminally ill.

We can try to resolve this worry by enacting a law that allows euthanasia only for "terminally ill" people.

But this lands us on the other horn. There are always those rare cases of someone – such as Tony Nicklinson in England – whose suffering is by all objective standards unbearable but there is no terminal illness. And this is the very case that prompted the UK Supreme Court to encourage parliament to consider legislation.

Nicklinson had a physical condition (locked-in syndrome), unlike Simona who had no physical ailment at all. So we could limit euthanasia to those who at least have a physical condition. But then, why should the option be limited to people with a physical condition?

There is no easy answer to this dilemma. But, to use a famous phrase, hard cases make bad law. I don't take this phrase to mean we should never legislate to cover the rare cases such as Nicklinson's, but only that we need to be really sure, and get it right, before we do.

As for the less rare cases, we should think instead of ways of helping people who suffer which don't involve encouraging them to end their lives.

1. Even though the author notes that Australian citizens widely support assisted suicide, or euthanasia, the government is hesitant to create a bill legalizing those rights. What are two reasons from the article for this? What are two more reasons you can think of?

2. Assisted suicide, when legal, is typically available only to those who are terminally ill and would die soon—except for the case of Belgium. Do you think limiting the right in this way increases the value on human life, as the author suggests? Explain your thinking.

"GUIDELINES FOR PHYSICIAN-ASSISTED SUICIDE," BY RAPHAEL COHEN-ALMAGOR, FROM *ADVANCES IN MEDICAL ETHICS,* OCTOBER 5, 2015

INTRODUCTION

Empirical research shows very clearly that most people would like to continue living. In my experience of having visited more than 30 hospitals in Israel, England, Canada, USA, Australia, New Zealand, the Netherlands and Belgium, most patients, even in the most dreadful conditions, opt for life - especially, it seems, if they are practising members of the Catholic, Jewish and Islamic faiths [1], but less so in the Netherlands and Flemish Belgium [2, 3].

The general picture is clear: we all possess a zeal for life. Therefore, whenever we are unclear about patients' wishes, the default position we should take is that the patients opt to choose life [4].

Only a small minority of patients expressly wish to die. This article discusses who these patients are, and further emphasises the importance of comprehensive palliative care. I voice my objection to euthanasia, insisting instead on a system of checks and balances that ought to be in place when a physician comes to a patient's aid. This plea is confined to physician-assisted suicide, wherein the patient themselves perform the final act.

THE 'ARGUMENT FROM AUTONOMY'

When speaking of death with dignity, the focus of attention is on the rights of the patients over their own body. The notion of autonomy involves the person's ability to reflect upon beliefs and actions, and ability to form ideas about these so as to

decide how to lead his or her life. The term ‘autonomy’ is derived from the Greek *autos* (‘self’) and *nomos* (‘rule,’ ‘governance,’ or ‘law’). By deciding between conflicting trends, patients consolidate their opinions more fully and review the ranking of values for themselves. Obviously, to be able to exercise autonomy, patients must have options to choose from; some may be of significance to the patient, others may not. Having options allows people to sustain activities they regard as worth pursuing. As Joseph Raz asserts, a person who has never had any significant choice, or was not aware of it, or has never exercised choice in significant matters but simply drifted through life, is not an autonomous person [5-9]. Choosing the best option or thinking correctly is not a requirement for autonomy so long as the agent exercises deliberation in assessing the alternatives. The emphasis is not on deciding the ‘best’ options or on holding ‘true’ opinions, but on the way in which we come to make our decisions and to hold our convictions.

The liberal state is founded upon the principles of autonomy and individuality: everything stems from the individual, everything returns to the individual. The state is perceived as a developed instrument to help sustain our individuality within a just society. It is far more powerful than a mere individual; it is a tool to enrich individuality, to enable people developing their innate capabilities to facilitate the progress of individuals, which, in turn, will yield societal progress. At the end of life, autonomous people may expect liberal society to address their needs and concerns, provided that these needs and concerns do not harm others, are deemed justified and are done in a *bona fide* manner.

The view that holds we should always preserve life no matter what the patient wants, and that patients who opt to die are unable to comprehend their own interests in a fully rational manner, and that therefore we know what is good for those patients better than they do, is morally unjustifiable because it ignores patients’ desires and fails to acknowledge that the preservation of dignity may be valued more by some patients than the preservation of life. We must strive to reconcile the duty of keeping patients alive with their right to keep their dignity, which may also be considered as an intrinsic value. Therefore, the request for assisted dying may be justified; it has a place in the framework of liberal-democracy, which should not turn a blind eye to such appeals. It should not desert its patients and should attempt to accommodate their needs.

THE ‘RESPECT FOR OTHERS’ ARGUMENT

This argument is derived from the Kantian deontological school that accords all people equal respect. Respect for a person means conceiving of the other as an end rather than as a means to something. As Immanuel Kant explains, a limit is imposed on all arbitrary use of people who are thus objects of respect. A person is, therefore, an objective end; such an end, Kant maintains, “is one for which there can be substituted no other end to which such beings should serve merely as

means, for otherwise nothing at all of absolute value would be found anywhere" [10].

According to Kant, to respect a person is to treat her as a human being, as an autonomous being who acts in recognition of the moral law. The assumption is that beings are moral, and Kant demands that people act in accordance with the Categorical Imperative: "act only on the maxim that can be universalized and that always treat humanity, yourself and others, as an end". In formulating his Categorical Imperative, Kant recognized that each person has an inviolable dignity, which is the reason for respecting other people. The Categorical Imperative refers to the will itself, not to anything that may be achieved by the causality of the will. Morality, according to Kant, cannot be regarded as a set of rules prescribing the means necessary to achieve a given end, whether the end be general happiness, human perfection, self-realization, or anything else. The postulate, "you ought never to tell lies" is an example of the Categorical Imperative. There is no way of evading the command or the moral requirement of practical reason that it expresses, for no end is mentioned and there is therefore no end that can be given up. (See [11-13] for further discussion.)

Kant does not speak of the process of decision-making. In contrast, I wish to emphasize the process of reaching a decision. In this process we exercise our faculties, using concepts, categories, principles, norms, and to some degree - whether we like it or cannot help it - our emotions. We construct and deconstruct realities, converse and exchange ideas, listen to the advice of others, and share our opinions with people we appreciate. At least on matters of importance, we strive to reach the right decision. As long as people accept the two basic principles underlying a liberal society: respect for others and not harming others, we accord others respect when we respect their right to make decisions because they are *their* decisions, regardless of our opinions of them. We assume that each person holds her own course of life as intrinsically valuable, at least for herself, and in most cases we respect the individual's reasoning. (On some issues the liberal state adopts a paternal approach that overrides individual decision-making: see [14, 15].)

We should give equal consideration to the interests of others and should grant equal respect to the others' life projects, so long as these do not deliberately undermine the interests of others by interfering in a disrespectful manner. As John Rawls asserts, "the public culture of a democratic society" is committed to seeking forms of social cooperation that can be pursued on a basis of mutual respect between free and equal persons [16-18].

Kant's line of reasoning should be supplemented by our emphasis on the notion of concern. We not only respect people, but we also care for them. Kant wanted to base his reasoning on logic, attempting to exclude emotional worries, but we need to acknowledge that peoples' acts are often dictated by emotions. Human nature enables us to rationalize but it is often controlled by emotional drives. Thus, it is not sufficient to speak only of respect: we should also speak of concern [19-23].

The notion of ‘concern’ signals the value of well-being: we ought to show equal concern for each individual’s good. Treating people with concern means treating them with empathy; viewing people as human beings who may be furious and frustrated, capable of smiling and crying, of careful decision-making and impulsive reactions. ‘Concern’ does not demand giving equal weight, utilitarian fashion, to the welfare of a stranger as to the welfare of a person’s children [24]. Instead, it means giving equal weight to a person’s life and autonomy.

Medical staff should do nothing that might impair the patients’ dignity in keeping them alive. Some situations present grave difficulties, but physicians and nurses are said to give their foremost concern to preserving the dignity of gravely-ill people. They take care of them; they clean them; they treat bodies that do not communicate with them as human beings. Physicians acknowledge that the introduction of tubes causes discomfort and may be painful to conscious patients. Any interference with the wholeness of the human body may be perceived as infringement of dignity. However, as long as patients are not perceived as a means to something, and the prevailing view regarding patients is as objective ends, the attitude towards patients can be said to respect their dignity. This view perceives the patient’s existence in itself as an end. Preserving patients’ dignity requires that no other object can be substituted for such an end.

Generally speaking, the common denominator among patients expressing a desire to die with dignity is a strong sense of autonomy. We are unable to control the moment we are born but we are able, to an extent, to control the moment we depart life. These patients insist on having this right: they wish to control the moment of their death and ask to die when life has lost its appeal for them. To them, continuous life is perceived to be disrespectful and agonizing, and they approach the medical profession for help because they wish the procedure to succeed first time, rather than take the risk that they might be forced to live with the deteriorated consequences in the event that their suicide attempt goes wrong. In Oregon, research over the past few years has consistently showed that the most frequently mentioned end-of-life concerns are loss of autonomy, a decreasing ability to participate in activities that made life enjoyable, and loss of dignity [25-30].

Patients who wish to die are usually inflicted with degenerative, incurable and painful diseases. They are gravely ill people who know that death is near, and who wish to cease their fight against it. Weighing the continuation of life against death they see more advantages in departing life than in maintaining it. In the Netherlands [31-34] and Belgium [35-38] most of the people who approach physicians with requests for physician-assisted suicide (PAS) and euthanasia are cancer patients. Cancer is a painful disease that inflicts significant suffering [39-42]. Many patients do not wish to fight against it for too long.

For some strong-willed, suffering patients physician-assisted suicide is a solution. They would like to decide the time of their death. Only they can say: “Enough is enough. Now it is time to say goodbye, because I can no longer cope

with my state, and because medicine does not have a cure for me." Physician-assisted suicide can be the solution, especially for suffering cancer patients, at the last stage of their lives. It is humane to cater for these people, enabling them to die in their own bed, in the company of their loved-ones. Respecting those patients dictates honouring their request to end their life-journey.

One of the conclusions I have reached during my 20+ years of research is to advocate voluntary physician-assisted suicide and not active euthanasia. Dutch people do not pay much attention to the distinction between the two, although it is viable. Physician-assisted suicide gives patients control until the very last moment of their lives, prevents possible abuse, and assures that they genuinely want to die. In most cases, patients are able to carry out the final act to terminate their lives. In rare occasions of complete paralysis or suffocation to death, when the patient is absolutely unable to move a muscle, only then may the doctors complete the final 'act of mercy' [1, 2]. It is one thing to support euthanasia on general moral principles, and quite another to support it in the face of reality. Ethically speaking, one may support euthanasia. Practically speaking, I do not, and as we are talking about end-of-life care, practical considerations outweigh unfounded, purely philosophical arguments. Indeed, for a number of years I supported euthanasia, believing in the fundamental right of patients to seek unqualified help from their physicians. However, I was forced to change my views after fieldwork in the Netherlands and Belgium, the two countries that have legalized euthanasia. A fine line distinguishes theoretical principles and health policy. To date, health policy in both countries is insufficient to prevent abuse. Every year, a worrying number of patients are killed without a pronounced wish to die [35, 43-48]. I cannot support such a system. Thus my plea is confined to physician-assisted suicide, where the patient performs the final act, not the physician.

GUIDELINES FOR PHYSICIAN-ASSISTED SUICIDE (PAS)

The right to die with dignity includes the right to live with dignity until the last minute, and the right to part from life in a dignified manner. There are competent, adult patients who feel that the preferable way for them to part from life is through physician-assisted suicide. The following is a circumscribed plea for voluntary physician-assisted suicide on their behalf.

GUIDELINES FOR PHYSICIAN-ASSISTED SUICIDE

1. Physicians are best equipped in terms of knowledge and expertise to provide aid-in-dying. It is the only profession that could come to patients' aid when they insist on their right to die. The medical profession is in flux. Rapid scientific and technological progress, the rise of chronic disease, the ability to

keep chronic patients alive for many years, and the democratization of knowledge are all important in the shaping of medicine. The medical profession should be attentive to wishes of all patients, and strive to accommodate their wishes. In this context, the Croatian Medical Chamber's Code of Medical Ethics and Deontology (2006) holds that: "one of the primary obligations upon a medical doctor who has a patient in care is to relieve that patient's pain and suffering. That is especially important in providing treatment and care to terminally ill and dying patients" [49].

2. The physician should not suggest assisted suicide to the patient. Instead, it is the patient who should have the option to ask for such assistance. Initiation by the physician might undermine the trust between the physician and the patient, conveying to patients that the doctor is giving up on them and values their lives only to the extent of offering assistance to die. Such an offer might undermine the will to live and to explore further avenues for treatment. Many Dutch researchers and physicians do not see this issue as a significant one [50-52]. Some of them consider it important to raise the issue when it seems as though patients would not dare to initiate it on their own. Undoubtedly, however, all people in the Netherlands are aware of the availability of euthanasia and physician-assisted suicide. Any reluctance shown by patients in regard to this issue should be honoured and respected.

3. The request for physician-assisted suicide of a competent adult patient suffering from an intractable, incurable and irreversible disease must be voluntary [53, 54]. The patient should state this wish repeatedly over a period of time. We must verify that the request for physicianassisted suicide does not stem from a momentary urge; an impulse or a product of passing depression. This emphasis of enduring request was one of the requirements of the abolished Northern Territory law in Australia [55], and is one of the requirements of the Oregon Death with Dignity Act [56] as well as of the Dutch and Belgian legal guidelines [57]. It should be ascertained with a signed document that the patient is ready to die now, rather than depending solely upon directives from the past. Section 2 of the Oregon Act requires

that the written request for medication to end one's life be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest to the best of their knowledge and belief that the patient is capable, is acting voluntarily, and is not being coerced to sign the request [56]. Individuals may express general attitudes regarding end of life in an informal discussion made in a social setting, possibly saying that they would not want to live if they were unable to function alone and had to depend on the mercy of others. However, such hypothetical observations do not constitute reliable evidence of a patient's current desires once an illness is in progress. This is especially true if the wish was stated when young and healthy. The younger people are and the further they are from serious disease, the more inclined they are to claim that in a hypothetical state of pain, degradation and hopelessness, they would prefer to end their lives. On the other hand, there is a tendency to come to terms with suffering, to compromise with physical disabilities, and to struggle to sustain life. This tendency grows as the body weakens. Many people change their minds when they confront the unattractive alternatives, preferring to remain in what others term the "cruel" world, and continue the Sisyphean struggle for their lives.

4. Thus the patient can rescind at any time and in any manner. This provision was granted under the Australian Northern Territory Act [70] and under the Oregon Death with Dignity Act [56]. Chapter III, Article 4 of the Belgian Euthanasia Law says that patients can withdraw or adjust their euthanasia declaration at any time [71].

5. At times, the patient's decision might be influenced by severe pain. The Oregon Death with Dignity Act requires the attending physician to inform the patient of all feasible alternatives, including comfort care, hospice care and pain control [56, 58, 59].

6. The patient must be informed of the situation and the prognosis for recovery or escalation of the disease, with the suffering that it may involve. There must be an exchange of information between doctors and patients (On this issue, see [56; section 3].

Many bill proposals to legislate PAS in the United States specify certain information that must be communicated by the physician to the patient before honouring his or her request.) [54, 56].

7. It must be ensured that the patient's decision is not a result of familial or environmental pressures. At times, patients may feel that they constitute a burden on their loved ones. It is the task of social workers to examine patients' motives and to assess to what extent they are affected by various external pressures (as opposed to a truly free will to die). A situation could exist in which the patient is under no such pressure, but still does not wish to be a burden on others. Obviously, we cannot say that the feelings of patients toward their loved ones are not relevant to the decision-making process [60-62].

8. The decision-making process should include a second opinion in order to verify the diagnosis and minimize the chances of misdiagnosis, as well as to allow the discovery of other medical options. A specialist, who is not dependent on the first doctor, either professionally or otherwise, should provide the second opinion [3, 54, 63]. A Dutch study revealed that the nature of the relationship with the consultant in the euthanasia decision-making process was sometimes unclear. The consultant was reported to have been an unknown colleague (39%), a known colleague (21%), other (25%), or not clearly specified in the report (24%). Review committees relatively often scrutinized the consultation process (41%) [64]. One Belgian survey revealed that 27% of physicians think that euthanasia is a private matter that does not need to be controlled by the Control and Evaluation Commission [65]. The patient's attending physician, who supposedly knows the patient's case better than any other expert, must be consulted, and all reasonable alternative treatments must be explored. The Oregon Death with Dignity Act requires that a consulting physician shall examine the patient and his/her relevant medical records and subsequently confirm, in writing, the attending physician's diagnosis that "the patient is suffering from a terminal disease." Furthermore, the consulting physician must verify that the patient is capable, is acting voluntarily, and has made an informed decision [56]. The

American Medical Association (AMA)’s council on ethical and judicial affairs suggests the participation of consultants to facilitate discussions that would help the parties reach a course of action. AMA strongly objects to PAS [66]. The Northern Territory Rights of Terminally Ill Act required that a physician who specialized in treating terminal illness examine the patient [55].

9. It is advisable for the identity of the consultant to be determined by a small committee of specialists who will review the requests for physician-assisted suicide. This is in order to avoid the possibility of arranging deals between doctors (“you will consult for me regarding Mr. Jones, approving my decision, and I will consult for you regarding Ms. Smith, approving your decision.” For further discussion in this context, see [67-69]).

10. Some time prior to the performance of physician-assisted suicide, a doctor and a psychiatrist are required to visit and examine the patient so as to verify that this is the genuine wish of a person of sound mind who is not being coerced or influenced by a third party. The conversation between the doctors and the patient should be held without the presence of family members in the room in order to avoid familial pressure. A date for the procedure is then agreed upon. The patient’s loved ones will be notified so that they can be present right until the performance of the act, making the day an intimate, family occasion.

11. Physician-assisted suicide may be performed only by a doctor and in the presence of another doctor. The decision-making team should include at least two doctors and a lawyer, who will examine the legal aspects involved. Insisting on this protocol would serve as a safety valve against possible abuse. Perhaps a public representative should also be present during the entire procedure, including the decision-making process and the performance of the act. This extra caution should ensure that the right to die with dignity does not become a duty, and it will contribute to reporting of cases. The experiences of both the Netherlands and Belgium raise alarm, as many end-of-life cases are not reported. In Belgium, only one out of two euthanasia cases is reported to the Federal Control and Evaluation

Committee [36, 72, 73]. The doctor performing the assisted suicide should be the one who knows the patient best, having been involved in the patient's treatment, taken part in the consultations, and verified through the help of social workers, nurses and psychologists that PAS is the true wish of the patient.

12. Physician-assisted suicide may be conducted in one of three ways, all of them discussed openly and decided upon by the physician and the patient together: (1) oral medication; (2) self-administered, lethal intravenous infusion; (3) self-administered lethal injection. Oral medication may be difficult or impossible for many patients to ingest because of nausea or other side effects of their illnesses. In the event that oral medication is provided and the dying process is lingering on for long hours, the physician is allowed to administer a lethal injection [74].

13. Doctors may not demand a special fee for the performance of assisted suicide. The motive for physician-assisted suicide is humane, so there must be no financial incentive and no special payment that might cause commercialization and promotion of such procedures.

14. There must be extensive documentation in the patient's medical file, including the following: diagnosis and prognosis of the disease by the attending and the consulting physicians; attempted treatments; the patient's reasons for seeking physician-assisted suicide; the patient's request in writing or documented on a video recording; documentation of conversations with the patient; the physician's offer to the patient to rescind her request; documentation of discussions with the patient's loved ones; and a psychological report confirming the patient's condition. This meticulous documentation is meant to prevent exploitation of any kind - personal, medical, or institutional. Each report should be examined by a coroner following completion of the physicianassisted suicide. Directive 6 in The General Manager Circular, Israel Ministry of Health (1996) states: "the decision to respect a patient's objection to a life prolonging treatment shall be documented in the medical statutes, expressing maximum

reasons for the decision and the discussions with the patient." [75-77].

15. Pharmacists should also be required to report all prescriptions for lethal medication, thus providing a further check on physicians' reporting [78].

16. Doctors must not be coerced into taking actions that contradict their conscience or their understanding of their role.

17. The local medical association should establish a committee, whose role will be not only to investigate the underlying facts that were reported but also to investigate whether there are "mercy" cases that were not reported and/or that did not comply with the Guidelines.

18. Licensing sanctions will be taken to punish those health care professionals who violate the Guidelines, fail to consult or to file reports, engage in involuntary termination of life without the patient's consent or with patients lacking proper decision-making capacity. Physicians who fail to comply with the above Guidelines will be charged and procedures to sanction them will be brought by the Disciplinary Tribunal of the Medical Association. The maximum penalty for violation of the Guidelines will be the revocation of the physician's medical license. In the event that this penalty proves insufficient in deterring potential abusers, there will be room to consider further penalties, including heavy fines and prison sentences.

19. An annual report should be published documenting all cases of aid-in-dying. The reports should be made available to the public. Discussions and debates about their findings should be promoted and encouraged.

CONCLUSIONS

Treating patients with respect means treating them as human beings who are capable of forming and acting on intelligent conceptions of how their lives should be lived. Respecting a person involves giving credit to the other's ability for self-direction; acknowledging the other's competence to exercise discretion when

deciding between available options. Accordingly, each person is viewed as speaking from that person's point of view, having perceived interests in his or her own way. We may be asked to give our opinions, or decide to express our views anyway; nevertheless, in many instances we recognize the other's right to make choices. This notion of autonomy is crucial in our considerations. The medical profession is required to respect the wishes of certain incurably ill patients.

While most patients prefer to continue living even when their health deteriorates significantly, some patients would rather die. The medical profession should not turn its back to these patients. The medical profession should cater to the needs of all patients, not only some of them. It should be cognizant of their self-perception and their subjective view of their dignity. The thesis is that patients, as autonomous moral agents, deserve to be treated with dignity and respect until the very last day of their lives. To do this requires an acknowledgement of their choices and life decisions. If a patient decides that her life is no longer worth living, we should respect that decision and not compel her to live. Coercion qua coercion is repulsive. At the same time, a voice of caution is raised in the conducting of mercy killing, thus detailed Guidelines are required to prevent abuse. As human life is at stake, caution is simply a must.

1. The author discusses how there is evidence that in some countries with right-to-die policies, patients can be killed without formally consenting to their death. What do you think of the author's guideline that affirmative consent must be made numerous times to ensure a patient truly wants to die?

2. Many of the guidelines are focused on preventing abuse of right-to-die practices by doctors. After reading the author's thoughts on this matter, do you think there are any other guidelines that should be in place that have not been considered?

3. What other issues can you think of that might require this kind of affirmative consent?

"DEATH AS A SOCIAL PRIVILEGE? HOW AID-IN-DYING LAWS MAY BE REVEALING A NEW HEALTH CARE DIVIDE," BY JILL D. WEINBERG, FROM *THE CONVERSATION,* JULY 11, 2017

The California Department of Public Health has just released a report that detailed the number of terminally ill patients over the past year who took advantage of the California End-of-Life Options Act (EOLA), a law that allows certain patients to request a lethal dose of medication to end their lives. This report comes a year after EOLA went into effect on June 9, 2016.

According to the report, 258 individuals began the end-of-life process, which requires multiple oral and written requests and discussions with doctors before receiving the medication. Of this group, 90 patients received a prescription to end life but did not take it, while 111 individuals died from ingesting the drugs.

Supporters believe aid-in-dying laws are important for terminal patients because they provide an option to end life on their terms, rather than in a hospital or hospice setting. Indeed, there is a growing consensus in the United States in favor of aid-in-dying. According to a May 2017 Gallup Poll, 73 percent of U.S. adults surveyed believe a doctor should be allowed to help a terminally ill patient end his or her life if the patient makes the request. Six states and the District of Columbia permit aid-in-dying, and more states are considering similar laws.

One critical question is whether these laws make the process accessible to everyone who wants this option.

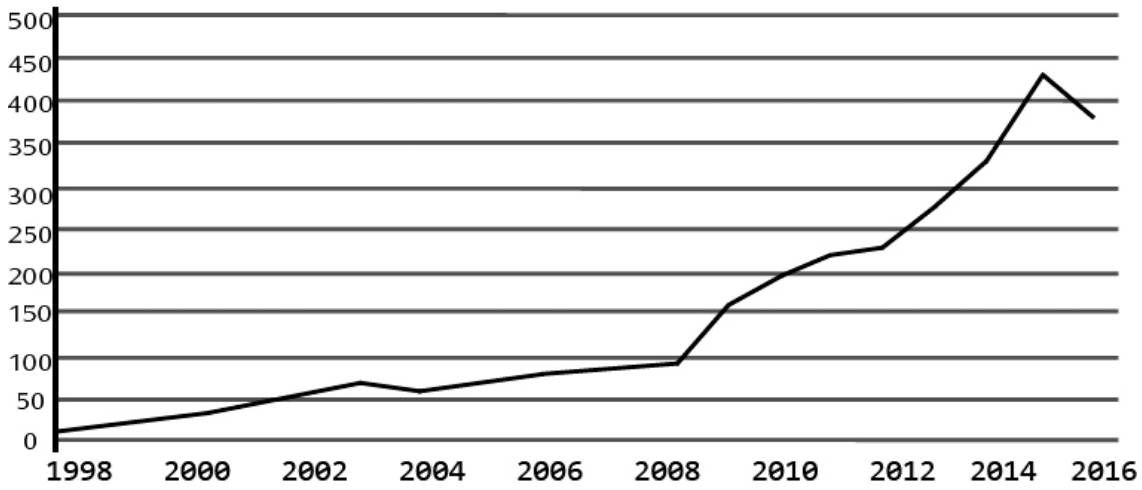
I am a sociologist who studies aid-in-dying laws and how law influences end-of-life choice. People often ask: Who is the typical person who pursues this option? My research looks at this question with data I combined from California along with Oregon and Washington, states that have published information about the people who use aid-in-dying laws.

A FAIRLY HOMOGENEOUS GROUP

In California, 258 people began the end-of-life process between June 2016 and June 2017, lower than the 431 requests in 2015 in Oregon and Washington combined. California’s EOLA may ultimately result in more requests, given the state’s large population.

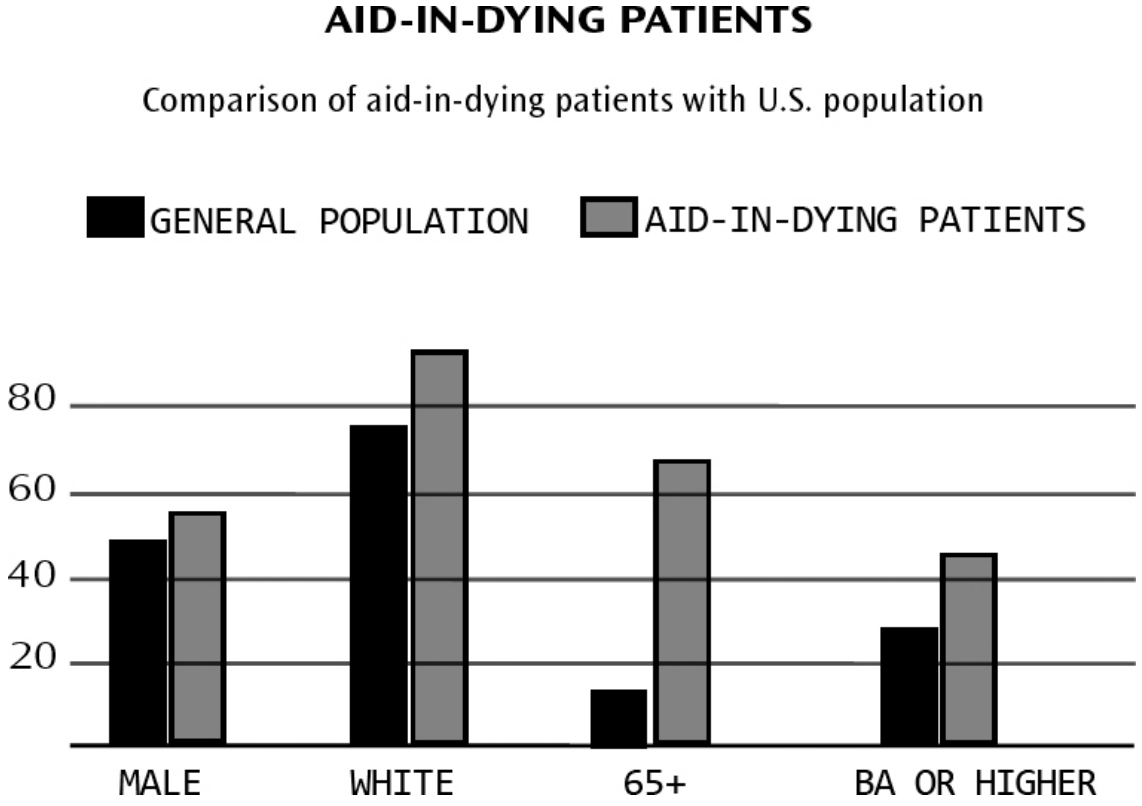
AID-IN-DYING REQUESTS IN CALIFORNIA, OREGON AND WASHINGTON

The total number of requests in California, Oregon and Washington has increased dramatically since 1998.



Data from California Department of Public Health, Oregon Health Authority and Washington State Department of Health.
The Conversation, CC-BY-ND

The numbers we have – predominantly based on Oregon and Washington patients – indicate that aid-in-dying patients are more likely to be male, white, over 65 years old and with the minimum of a bachelor's degree.



Why is a fairly homogeneous population using these laws more than others?

There may be many factors why these older white men are overrepresented, including access to doctors willing to help, religious beliefs or having peers with similar attitudes about aid-in-dying.

It is important, however, to also consider other explanations that may restrict access for certain populations.

Physicians are not required to help a patient who requests end-of-life options. New research shows that doctors struggle with professional and personal ethics around helping terminally ill patients and whether they should be required to inform patients who may not know about these laws.

Also, studies suggest racial differences about end-of-life choices are both cultural and structural. Pew Research Center shows African-Americans and Latinos are more religious, which includes belief in God, church attendance and prayer. Virtually all religions condemn aid-in-dying except the Unitarian Universalist Church. Religiosity explains a possible correlation between race and attitudes concerning aid-in-dying.

However, studies also report racial disparities with end-of-life care can be explained by the high cost of health care, lack of awareness regarding end-of-life care options, language barriers and high levels of distrust in medical professionals.

The growing number of aid-in-dying laws in more racially diverse states may change these trends. California is more diverse than other states, so it will be a

state to watch in the years to come.

BARRIERS IN LIFE AND IN DEATH

As more states consider aid-in-dying laws and discussions around end-of-life options are growing, it is important to question the statistics and what they do and don't reveal.

Statistics about aid-in-dying provide transparency concerning a process where patients are given an option over their end-of-life plans. Statistics also reveal that not everyone who pursues aid-in-dying actually takes the medication. In fact, 42 percent of patients who received medication did not ingest it.

Some organizations are advocating on behalf of patients who would like to end their lives. Organizations such as Compassion & Choices and the Coalition of Compassionate Care of California work to bridge the gap between patients and providers by offering presentations to doctors and directories of medical professionals willing to help patients who choose this route.

The statistics are important to help identify patterns that may be the result not simply of different attitudes about end-of-life options, but rather structural barriers that keep certain groups from pursuing options at life's end.

1. The author argues that assisted suicide rights are more likely to benefit a particular class of people: older white men. Based on what you've read, what are three reasons for this?

2. What are three ways that end-of-life care could be opened up to other classes of people?

"STOIC DEFENCE OF PHYSICIAN-ASSISTED SUICIDE," BY FLORIS TOMASINI, FROM *ACTA BIOETHICA,* VOL. 20, NO. 1, JUNE 2014

Abstract: Rational suicide can be minimally defined as: instrumentally rational, autonomous, due to stable goals and not due to mental illness. One major problem with rational suicide is that it tends toward a technical psychiatric definition, excluding any philosophical explanation of why rational suicide could be ethically justified. In other words, there is a tendency towards an instrumental view of rationality which concentrates on safeguarding the rational means of suicide, rather than fully considering the rational ends of why suicide could be ethically justified in certain special and controlled circumstances. To begin, the plausibility of rational suicide is explored. Following on, the classical stoic idea of

rational ends of suicide is then reframed for a more contemporary audience in the socially relevant context of physician-assisted suicide.

Key words: rational suicide, stoicism, self-preservation, physician-assisted suicide

HISTORICAL BACKGROUND

Our attitude and understanding of suicide has dramatically changed over time. Although it is unrealistic to chart a detailed history of suicide, it is possible to understand some of the broader shifts in perspective that contest the rationality and morality of suicide. There are three broad constituencies of debate around suicide: theological, psychiatric and philosophical.

The prevailing view against suicide arises out of the theological constituency of debate and the idea that all life is sacrosanct. It has deep roots in Judeo-Christian theology and philosophy. In Aquinas' view, for example, suicide is wrong because only God can take our lives away. Also, he believes the act of suicide is contrary to Nature *(1)*. Suicide is considered to be self-murder and a terrible sin that has deep historical roots. For example, Catholics still debate whether the soul of a suicide will be denied salvation in the after-life by being sent to purgatory. Furthermore, the sin of suicide was considered to be heinous crime; since as recently as 1860 attempted suicide was punishable in England by death. From 1917 to 1983, the church's Canon Law said that 'those who killed themselves of a deliberate purpose' were to be deprived of ecclesiastical burial. This provision was dropped from the revised Code of Canon Law promulgated by Pope John Paul II in 1983, which is still the current norm. However, 'grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide'.

OVERVIEW OF APPROACH AND METHOD

The contemporary debate over suicide has shifted away from theology to psychiatry and philosophy. The main objective of this paper is to defend rational suicide in the context of physician-assisted suicide.

Before this is possible it is necessary to outline the methodology of the study undertaken and to preview the logical sequence of the argument and results as it unfolds in the text. There are three parts to the argument, which characterise three distinctive approaches or methods. The first part of the argument is largely a critical review of whether rational suicide is at all possible. Some commentators have tended to criticise the plausibility of the notion of rational suicide on the grounds that it is: conceptually unintelligible; morally impermissible and; a sign of mental illness. The methodology behind the first third of the paper is to present a critical review of the negative case against the plausibility of rational suicide. The logical sequence of the negative case against rational suicide is based on a philosophical discussion and evaluation of the following questions:

(1) Is suicide intelligible (or conceptually rational)?

(2) Is suicide ever a morally permissible act (or morally rational)?

(3) Can suicide be competently chosen (or mentally rational)?

Having dismissed a negative case against the plausibility of rational suicide, a positive and more persuasive case is made for why rational suicide should be taken seriously in the modern context of physician-assisted suicide. In order to do this, the methodology reverts from critical analysis (of previous writers on the subject) to a more original conceptual analysis of a classical stoic defence of rational suicide, which is then reframed as a neo-stoic perspective on physician-assisted suicide. The logical sequence of this argument is as follows:

(4) Rational suicide from a classical stoic perspective

(5) A neo-stoic perspective on rational suicide in the context of physician-assisted death

Finally to look at the plausibility of the positive case for rational suicide, the argument ends with a methodology that involves 'empirical philosophy', that is an empirical assessment of the rationality of physician-assisted suicide in an institutional setting (the discussion of two case studies at Dignitas). By way of conclusion, there is a short evaluation of the meaning and importance of the study as well the limitations and implications for future research.

That is,

(6) Case studies in physician-assisted rational suicide

(7) Conclusion

IS RATIONAL SUICIDE A PLAUSIBLE NOTION?

(1) IS RATIONAL SUICIDE INTELLIGIBLE?

Suicide is taken from the Latin sui meaning of 'oneself' and cidium meaning to 'slay or kill'. However, the very intelligibility of self-slaying is questionable without prior cause, since suicide is, generally, not chosen for its own sake. It is fairly unintelligible to 'wish to be dead' for no reason. Suicide is intelligible if it is understood as having an antecedent cause, often in respect to relief from certain kinds of physical pain or psychological anguish *(2)*. Whereas, suicide, commonly understood – as a relief from physical pain and psychological anguish – may have an intelligible cause, it may still not be a rational act. Whilst the cause of someone committing suicide, from a third person perspective, may be intelligible, the act itself may seem insufficiently rational by virtue of the fact that it stems from mentally incompetent decision-making. In other words, most suicide attempts are made by people who are either, mentally ill or, are under enough mental duress, so as not to act in their best (long-term) interests.

Devine presumes that there is no after-life and that we are annihilated by death. Because of our presumed annihilation, Devine argues that death is un-experiencable and therefore any outcome – the cessation of pain or psychological anguish, for example – is unexperiencable and unknowable. Furthermore, since it is Devine's view that the precondition of a rational choice 'is that one must know what one is choosing' *(3)*, it is not rational to kill oneself unless one has full knowledge of what the alternatives are.

Philip Devine's argument is taken to task by Mayo *(4)*. What follows is a short summary of Devine's argument and Mayo's criticisms of it.

There are some serious problems with this view, according to Mayo. First, the presumption that death is annihilation and cannot be experienced is questionable. Some might refer to religious belief in the after-life or 'neardeath' experiences to question the unexperiencable nature of death. Even if we grant Devine his presumption that death cannot be experienced it still seems suspect to equate the unexperiencable with the unknowable: following Mayo, 'if we have a good reason to believe that death is annihilation, it is difficult to understand what more needs to be known about it before it can be said to be known' *(4: 151)*.

Finally, according to Mayo, Devine seems to be functioning with a form of 'rational choice' where one must have complete knowledge of alternatives. He is, therefore, operating with a standard of rationality that is difficult to attain in any practical sense. In everyday life we routinely operate on the basis of imperfect knowledge, rationally choosing between an unknown and a known evil. So, while it may not be rational to opt for death as an unknown for its own sake, it maybe rational to gamble on the uncertainty of death, when the outcome of suicide is to end a life that is experienced as incontrovertibly hopeless.

By way of a summary: first, the unexperiencable nature of death as an outcome of suicide does not rule out, tout court, its rational sense in a life experienced as hopeless. And second, while suicidal ideation is intelligible, it is, more often than not, carried out by mentally incompetent persons who are not acting in respect to their long-term values and interests. Therefore, the intelligibility of suicide does not fully secure its rationality as either a morally acceptable act or, as competently chosen one.

(2) IS SUICIDE EVER MORALLY PERMISSIBLE?

Another fundamental issue concerns the moral permissibility of the suicidal act. Some argue that suicide is morally irrational because it violates a fundamental view that human life is sacrosanct. This view originates in a deontological perspective on morality which holds on to the idea of sanctity of life: human life is intrinsically and inherently valuable, our duty being to honour and preserve ourselves and others no matter what *(2,5)*.

There are a number of difficulties with this kind of view.

First, the intrinsic value of a life is independent of extrinsic criteria on which the quality of a life may be judged e.g. health and happiness. Any life, therefore, is intrinsically valuable regardless of what kind of life it is and what sort of

suffering is endured. Singer cited in the Stanford Encyclopaedia of Philosophy *(5)* argues that this view misplaces the value of what it is to be living a life. For Singer, extrinsic criteria, like quality of life, are indicators of the value of a life lived. From this perspective, suicide may be morally permissible, if the quality of a life is chronically low and is likely to remain so in the future e.g. in the case of a terminal illness.

Second, it is perfectly possible to value the sanctity of life and still commit suicide. Indeed, Dworkin (1993) cited in Stanford Encyclopaedia of Philosophy admits 'that those who engage in suicidal behaviour, when the future promises to be extraordinarily bleak, do not necessarily exhibit insufficient regard for the sanctity of life' *(5: 11)*.

Finally there are even some of those who accept 'the sanctity of life' principle and agree that suicide may affirm life's value if the agent's future prospects are bleak. For some of these commentators like Cholbi *(2,6)* it might be morally rational to reject a life that misses certain essential qualities for a dignified human life. Cholbi's goes some way to meet the stoic case for rational suicide that follows.

In sum, it does seem that there is a morally rational case for suicide, but only if the agents quality of life is particularly poor and hopeless. Crucially this cannot be secured unless suicide is acted upon by a mentally competent agent.

(3) CAN SUICIDE BE A MENTALLY COMPETENT DECISION?

Suicide is the main cause of premature death amongst people with mental illness. It is estimated that 10% of people with mental illness suicide within the first 10 years of receiving their diagnosis. Suicide is a more common cause of death among people with schizophrenia and mood disorders such as bipolar disorder and depression, compared to the general population. People with personality disorders and disorders of addiction also have higher rates of suicide than the general population[1].

Mental illness significantly impairs rational choice. The way rationality is impaired depends largely on the nature of the mental illness suffered. So, according to Brandt *(2)* cited in the Stanford Encyclopaedia of Philosophy, a clinically depressed person will have difficulty in projecting himself, beyond his present frame of mind, to take into account his values and preferences.

Since there is a strong correlation between suicide and mental illness it is unsurprising that there are many contemporary critics arguing against the possibility of rational suicide. For example, many psychiatrists see suicide as inherently irrational because suicidal ideation is indicative of some underlying form of mental illness or disorder.

Just because there is a strong correlation between suicide and mental illness does not mean that all suicidal behaviour can be explained away on the basis of people having mental illness. Indeed, some psychiatrists feel a need to distinguish between those suicidal people who commit suicide because they are temporarily mentally incompetent due to a disturbed state of mind, and a much smaller group

of mentally competent people who commit rational suicide after a realistic appraisal of their longterm situation. For example Mayo *(4: 147-149)* reviews the approach of the psychiatrist Jerome Motto in this regard. Mayo's argument about Motto's approach is worth summarising in respect of rational suicide as competently chosen suicide.

As a practising psychiatrist, Motto's chief concern is when it is and when it is not appropriate to intervene to prevent suicide. For Motto the notion of rational or irrational suicide bites at the point of suicidal ideation in a clinical setting. Motto introduces two conditions for rational suicidal ideation. First, it must conform to rational beliefs about options and consequences of the decision to suicide. This screens out irrational suicide on the basis of unrealistic beliefs, for example,

'I will never get over my feelings for the lover who rejected me' *(4: 147)*.

Second, Motto addresses the notion of irrational suicide by screening out decisions based on transitory desires, which run counter to a person's more fundamental values. This deals with many suicidal desires we may impulsively act on when life might not be going so well for us, forgetting that emotional pain is often transitory.

In sum, there are some subtleties of meaning that need to be established between mental incompetence as allied to mental illness and mental incompetence in respect to sound clinical decision-making. That is, suicidal ideation is indicative of an underlying mental illness which, by definition is non-rational. However, there are some, like Motto, who believe that suicide maybe rational, if a patient's decision is based on realistic beliefs and in accordance with their long-term values. Interestingly from this perspective, mental incompetence may not be synonymous with mental illness, since the rationality of decision-making is more about good judgment, than any underlying mental health issue.

(4) RATIONAL SUICIDE FROM A CLASSICAL STOIC PERSPECTIVE

Sellars argues that the foundation of stoic ethics lies in the desire or drive that human and non-human animals have for self-preservation(oikeiosis) *(7)*. According to Sellars, the ends that contribute to preservation of nonrational animals are: water, food, shelter, etc. For a rational adult human being, however, to survive as rational human animals and not merely as an animal per se, we need pursue those things that preserve our rationality as well as our body. In short, we need to preserve the rationality of our souls as well as the biology of our body's *(7: 108)*. By way of an example, Sellars paraphrases Epictetus:

> 'If a tyrant threatened to kill a stoic, if the stoic did not agree to do certain things he found deeply objectionable, then, in order to secure his self-preservation, the stoic would have to stand up to the tyrant, even if it meant the loss of his own life' *(7: 109)*.

If one breaks down what rational self-preservation amounts to from a classical stoic perspective, it involves three key elements:

1. An unavoidable conflict: usually brought about by a tyrannical dictator who forced a stoic to sacrifice his values in exchange for his life. In terms of rational self-preservation, in order to preserve the virtue of one's soul, it was sometimes necessary to die honourably by sacrificing one's biological existence.

2. An intrinsic appreciation of intrinsic human ends over extrinsic needs: the virtuous soul is intrinsically essential to rational life in comparison to bare/biological life (which supports but does not hold our virtue).

3. A maximal notion of the good life: classical stoic suicides tended to be honourable, if not heroic, attempting to preserve the perfectibility of a virtuous existence.

Having outlined the classical case for rational suicide, it is necessary to see how such stoicism may be contextualised in a modern context.

(5) A NEOSTOIC PERSPECTIVE ON RATIONAL SUICIDE IN THE CONTEXT OF PHYSICIAN-ASSISTED DEATH

Mayo is a philosopher who has made connections between stoicism, rational suicide, mental competence and voluntary euthanasia. Mayo begins by quoting Seneca: '…It is not of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill' *(4: 143)*. In doing so, he aligns himself to a general stoic position. That is, it is sometimes rational to commit suicide for 'good reasons', 'in keeping with the agent's fundamental interests' *(4)*. Mayo goes on to explore this in a more contemporary context, reviewing the argument from more of a psychiatric, rather than philosophical, point of view. From psychiatry he argues that suicide can be rational if it is competently chosen; by that he means if it is a decision based on realistic beliefs aligned to one's long-term values. He also makes the point that stoicism was at the heart of those early campaigners of the British Voluntary Euthanasia Society who in 1969 were narrowly defeated in their attempt to legalise active voluntary euthanasia *(4: 149)*. While Mayo's paper is a thoughtful and excellent critical review of the concept of rational suicide from a number of different constituencies of debate, this paper looks at rational suicide from a more in-depth philosophical and stoic point of view, within the narrower context of physician-assisted suicide.

Before going on, it is important to distinguish rational suicide from regular suicide. In simple terms, regular suicide may be rationally intelligible, but it is not a rationally competent decision based on an appreciation of intrinsic human ends. Rational suicide per se is not only competently chosen but also aligns to long-term values and interests that are in accord with a notion of a good life, even if, in the case of physician-assisted suicide this is understood in minimal rather than maximal sense.

Interestingly the classical stoic perspective on rational suicide: (a) an unavoidable conflict (b) an intrinsic appreciation of human ends (c) a notion of

the good life, repeat with a difference, in the more contemporary context of physician-assisted suicide.

For example, the most compelling context for stoic (rational) suicide is in the case of terminal and/or chronic illness. Here a medicalised death can sometimes throw up an unavoidable conflict between prematurely ending a human life with dignity on the one hand and the technical capacity to prolong bare biological life on the other. In such cases, in order to affirm the preservation of our rational self, we may have to sacrifice our biological self prematurely.

Furthermore, a key difference between the classical stoic and modern stoic has to do with the 'form of life' *(8)* in which the preservation of long-term values is understood. An ideal rational suicide in the context of a medicalised death secures what is essential to a minimal rather than a maximal form of human flourishing. In other words, the neo-stoic attempt toward rational suicide may provide a context for a physician-assisted suicide where there is a desire to preserve a minimal sense of a good human life with recognizable and intrinsically valuable human ends. The minimal good of self-preservation is not the maximal notion of the perfectibility of the rational soul (as in classical stoicism), but the self-preservation of a minimal good in terms of 'care of the self'. Minimal self-preservation of human flourishing can be thought of in terms of the 'care of the self' rather than 'care of the soul' and, in the context of physician-assisted suicide, can be understood to be about preserving the intrinsic value of the autonomy, quality and the purposefulness of our humanity at the end of life.

Having outlined how neo-stoicism may be used to justify the rational suicide of terminally ill patients, it is important to have some understanding of the physician-assisted context, in which this can take place.

Some commentators draw a distinction between active voluntary euthanasia and physician-assisted suicide, arguing that the latter is an attempt to stop short at the physician 'bringing-about the death of patient'. In this way professional agency is carefully restricted to a more passive role of safeguarding the rationality of suicidal ideation and the patient's true self determination to follow through with the act of suicide. Rational suicide cannot simply be equated to physician-assisted suicide, unless the physician has carried out their duty of care to the patient; making sure that their choice to suicide, is at least mentally competent.

Interestingly this is exemplified by the Swiss organisation Dignitas who are the only organisation that assist 'suicide tourists' in their desire for a rational suicide[2]. It is the client that: initiates the request for suicide; demonstrates their rational self-determination to responsibly carry through suicide without harm and interference from others and; activates and controls the means and timing of their own death. Nevertheless, there is much debate about whether Dignitas always secures a 'good death' in terms of minimal notion of human flourishing. Physician-assisted suicide is just one form of rational suicide and cannot be assumed to be rational unless it really is freely chosen by a mentally competent patient who, in a sense, is 'forced' to choose a dignified human end in the face of a terminal illness that necessarily robs them of their dignity. To avoid a rogue or irrational physician-

assisted suicide, the physician needs to make sure that the patient is making a voluntary and mentally competent choice to die. In addition medical doctors need to rely on an objective medical prognosis where there is clarity about the fact that minimal expectations of what constitutes the preservation of a good human life will definitely be outstripped by the course of disease.

Crucially if we are to have a thick and rich notion of rational suicide, we need more than just a set of technical reasons, why it is a good idea. The philosophers Pilpel and Amsel have recently criticised rational suicide on these grounds, arguing that technically rational suicides, can still be a 'bad mistake'. They argue that many proponents of rational suicide 'out of a concern for autonomy and self-determination, are loath to claim that people's choice of suicide is wrong unless there is something technically wrong with their reasoning' *(1: 111-123)*.

In short to have a robust view of rational suicide in the context of physician-assisted suicide we need a moral as well as technical rational. In other words, rational suicide is rational if it is:

An instrumentally rational choice: where rational self-preservation involves making a mentally competent choice based on their realistic beliefs and their longterm values.

An intrinsically rational choice: where a person making a decision to suicide has the moral insight to preserve a minimal notion of human flourishing in spite of the medical promise of life stripped to bare biological function.

(6) CASE STUDIES IN PHYSICIAN-ASSISTED RATIONAL SUICIDE

Having provided a theoretical outline of a stoic defence of rational suicide in the context of physician-assisted suicide, it is worth doing a little 'empirical philosophy' to illustrate the plausibility of the case.

Before illustrating some of what has been discussed in neo-stoic terms, it is important to point out that rationally motivated physician-assisted suicide should never be morally obligatory. That is, we can only realistically expect medical professionals to offer their assent and assistance in our desire to die with dignity if they share some of our fundamental values on the intrinsic worth of a human life. This distinction can be illustrated through two case studies from the documentary 'The Suicide Tourist'[3].

The first case study concerns a suicide pact.

George and Betty Coumbias entered into a suicide pact when George's health seriously deteriorated after he'd had three heart attacks. Because George's lifetime partner, Betty, could and would not live without her husband, they approached Dignitas in Switzerland to request assistance with a double suicide. What made the case particularly controversial (even for the most liberal interpretation of rational suicide) was that Betty Coumbias had no significant health problems.

Neither Betty nor George had presented any obvious technical reasons why their request for physician-assisted suicide should be denied. They both entered into a stable and deliberate decision to end their lives (George and Betty had

entered a suicide pact long before either one of them had become ill and now that George was gravely ill, Betty could not contemplate a life without him). They were not mentally ill (they might have been in a heavily co-dependent relationship, but neither were obviously mentally ill) and they had not neglected their responsibility to others (both their daughters had been informed and supported them in their decision). In short, some might argue that the couple's choice may have been perceived and defended as the best possible decision for them, given their particular circumstances.

It is difficult, in the case of Betty, to shake off the intuition that she was throwing her life away for reasons that are not good enough.

From the perspective of a physician, it is an anathema to assist in the suicide of a patient who is not in a hopeless medical condition. While George is gravely ill, Betty is perfectly healthy and therefore helping her commit suicide is an obvious affront to the Hippocratic Oath.

Betty is not obviously mentally ill. However, her mental competence is doubtful given her deeply co-dependent relationship with her husband. In this sense, it might be argued, that her inability to even consider continuing her life without her husband at her side is not rational. Furthermore, it is unclear what the urgency for a suicide pact is when she would not have to give up the option of killing herself later on if she indeed found life without her husband to be unbearable.

The clinical decision-making in this case is highly contestable; that is, while Betty Coumbias was not obviously mentally ill she still may have been mentally incompetent. As argued elsewhere, mental illness and mental incompetence are not necessarily synonymous. In Betty's case the fact that she wasn't mentally ill did not necessarily guarantee her mental competence.

It is interesting that the director of Dignitas, Ludwig Manelli, initially supported the couple's request for consideration of physician-assisted suicide – even though the request was finally turned down by the attending physician, who under pressure from the Swiss authorities, refused to give his consent. Manelli's justification was that 'it (suicide) should always be the decision of the individual', providing there is no obvious technical reason for the request to be denied.

Manelli's point of view is based on the thin account of what is a technically justifiable idea of a good death. This leads to disturbing libertarian relativism. That is, there is little point in medical professionals acting as gatekeepers, preventing non-rational assisted suicides, if rational suicide is merely permission to assist those technically sane individuals who can weigh up the pros and cons of continued life, and then decide in favour of death. This leaves the door open for suicide on demand; a possible choice for anyone who is autonomous, without a mental illness and reasonably responsible, but perceives, for one specious reason or another, theirlife turning out badly.

From a psychiatrist like Jerome Motto's point of view, it is unlikely that Betty's decision to enter into a suicide pact with her husband George was competent. Motto provides a thicker and richer account as to what constitutes a clinically

good reason to entertain rational suicide. From his point of view, it might be argued that Betty's incompetence arose from the fact that she could not even entertain the possibility that she might be able to create a meaningful life in the absence of her husband, or that she would not be giving up the option of killing herself later on.

Concentrating on instrumental technical reasons alone for justification of rational suicide is, in the author's view, insufficient explanation as to why rational suicide may or may not be a good idea. So, even if we follow the more responsible psychiatrist, Motto (whose position gives a reason to suggest why Betty Coumbias may not be mentally competent for physician-assisted suicide), it still begs certain fundamental philosophical questions as to why Betty killing herself would be bad mistake.

Betty's intransigence at not being able to imagine a meaningful or happy life without her husband is a mentally incompetent decision. However, that mental incompetence stems from her failure to recognise the intrinsic value of her life. That is, Betty's suicide would not have preserved the intrinsic worth of a life thrown into stark relief by an unavoidable conflict between a minimally worthwhile human flourishing on the one hand and bare biological life on the other. Betty does not have a terminal illness, she is relatively healthy. Moreover her life is not psychologically hopeless; she may still live a meaningful and happy life after her husband dies, alone or with someone else. In sum, her suicide would not have been rational in a more philosophically stoic sense.

The second case concerns a person with a terminal illness.

This case followed Craig Ewart a 59 year old retired professor who approached Dignitas for an assisted suicide. He had a terminal disease called Amyotrophic Lateral Sclerosis (ALS is a form of Motor Neuron Disease). ALS attacks nerves and muscles so that sufferers progressively lose function: the ability to stand, walk, get in and out of bed on their own, use hands and arms and eventually breathe (unassisted) and communicate.

Ewart's request for assisted suicide was approved by Dignitas. He ended his life by determining the place and time of his death in Switzerland and voluntarily accepting a liquid sedative (before he lost the ability to swallow) that would end his life after he disconnected himself from his artificial breathing apparatus. Craig's choice was instrumentally rational in all the usual senses: it was a stable and considered choice (Craig had made the choice, with the help of his wife and family, well before ALS became acute); it was a competent choice (Craig's mental health was good, he was still enjoying life and not depressed); it was responsible to others (he had taken into account how his illness was impacting on his family and discussed that he and they would be better off if he committed suicide); it was the best choice given his circumstances (ALS is a progressive terminal disease, where there is no guarantee of not suffering).

In his own words:

> "Most statements that you read about the disease are most people have a peaceful death. That's fine for most people, but what if I am the one that

> doesn’t have a peaceful death? What might be peaceful from the outside does not necessarily reflect the internal state of that person. Let’s face it when you are completely paralysed you can’t talk, you can’t move your arms, your eyes, anything, how do you let somebody know you are suffering? … At this point I’ve got two choices. Either I go with it or I say you know what I’m too scared right now I don’t want to do it. If I go with it, I die, as I know I must soon die, at some point. If I don’t go through with it my choice is to essentially suffer and to inflict suffering on my family and then die, possibly, in a way that is considerably more stressful and painful than this way. I’ve got death and I’ve got death with suffering” .

Craig’s choice is not only instrumentally rational in all the usual senses, it is also substantively rational. It is substantively (or philosophically) rational because he recognises the ‘unavoidable conflict’ between the distinct possibility of ‘death and death with suffering’ . Moreover, there are some terminal diseases, like ALS, where our animality outstrips our capacity to preserve what we value about living life as a human being. When Craig was diagnosed with ALS and started to contemplate suicide he recognised the tension between human life and bare life: ‘you can only watch so much of yourself drain away and say, at some point, this is an empty shell’ . Therefore, for the sake of preserving his humanity, it makes sense, in this more substantive stoic sense, for Craig to have seriously contemplated ending his life prematurely. Finally there is evidence that Craig understood and appreciated joy, which was essentially about life despite the progression of the disease: ‘I still enjoy living enough that I’d like to continue. But the thing is I really can’t, I am not tired of living I am tired of the disease’ . Craig, right up until his very end, still appreciated the intrinsic goodness of his life as a human being but realised that there was no way of preserving this without, ironically, committing suicide and putting a stop to a disease that was robbing him of his humanity. His happiness had to do with the appreciation of his human capacity to still enjoy life while he could. Likewise his fear of suffering had to do with a fundamental fear that this could no longer be humanly communicated, understood and, therefore relieved.

(7) CONCLUSION

Having made a special case for rational as opposed to regular or irrational suicide, it has been argued that rational suicide is particularly relevant when considering physician-assisted suicide. In arguing for the connection between the two there has been attempt to offer a stoic defence of rational suicide. In doing so, it is argued that for physician-assisted suicide to be fully rational it must preserve both competent decision-making to rational suicide as well safeguarding a shared sense of the intrinsic value of what makes human beings ‘human’ at the end of life.

The originality and importance of the paper lies in the fulsome nature of the neo-stoic defence of rational suicide in physician-assisted death. Whilst Mayo is the first to make the connection, this paper makes clear the classical stoical roots

of this argument andhow it maybe reframed in the context of physician-assisted suicide.

This said there are limitations to the results of this study. That is, whilst it is perfectly possible to present a cohesive and persuasive philosophical argument for physician-assisted rational suicide, it is quite another matter to safely secure rational suicide in an institutionally robust setting. As previously argued, Dignitas does not always inspire confidence in securing the neo-stoic ideal of rational suicide (as evidenced by Coumbias case). As such, the implications for future research are more practical than philosophical: one might, for example, study how to secure rationally physician-assisted suicide in a robust institutional setting or, one could look into devising a robust legal framework.

1. The author discusses the case of Betty and George Coumbias, where one patient requesting assisted suicide services is terminally ill (George) while the other (Betty) is not, and simply wants to end her life. The two doctors mentioned in connection with the Coumbias case had differing ideas about whether the Coumbias should be allowed to end their lives. Based on what you've read so far, discuss which side you would have taken in the Coumbias case and why.

2. What is the difference between rational and regular suicide? What are some problems that you think could arise by defining rational suicide the way the author has?

CHAPTER 2

WHAT THE GOVERNMENT AND POLITICIANS SAY

After Dr. Jack Kevorkian was arrested for aiding in the deaths of more than one hundred patients, assisted suicide became not only a medical and moral issue, but a political one as well. The right to die is incredibly controversial, and in the states and countries where assisted suicide is permitted, there has been much political debate about whether the government has the right to interfere in people's lives or if they have the obligation to help keep people alive. In the following articles, you'll see how governments have chosen to handle the issue so far and be asked to consider how you would decide on the right-to-die issue if you were in office today.

"GOV. HICKENLOOPER SIGNED MEDICAL AID-IN-DYING INTO LAW TODAY. NOW WHAT?," BY KELSEY RAY, FROM *THE COLORADO INDEPENDENT,* DECEMBER 16, 2016

Gov. John Hickenlooper signed Proposition 106 into law today, thus legalizing medical aid-in-dying in the state of Colorado. Qualified, terminally ill patients may now begin to legally obtain prescriptions for lethal doses of barbiturates to voluntarily end their lives.

Kat West, policy director of aid-in-dying advocacy group Compassion & Choices, the main backer of the measure, expects that patients will now begin requesting the life-ending medication, if they haven't already. "I can tell you, on day one, patients are going to be asking about it," she told *The Colorado Independent* last week. West used California as a model, which saw patient requests as soon as the law went into effect on June 9 this year.

Interested patients must wait 15 days from their initial request to receive a prescription, so it's unlikely the drugs will be prescribed until the new year. If patients have already spoken to their doctors about a prescription, however, they could receive the medication sooner.

State voters passed medical aid-in-dying by a two-thirds majority on election night. Colorado is now the fifth state in the nation to pass an aid-in-dying law, along with Oregon, Washington, Vermont and California. Montana has no such law, but the state Supreme Court ruled that aid-in-dying is not illegal there.

To qualify for medical aid-in-dying, patients must be Colorado residents, be at least 18 years old and have a terminal illness diagnosis with six months or fewer to live. They must also be of sound mind and have the approval of two different physicians. The medication must be self-administered.

In preparation, for the new law, Compassion & Choices launched a "massive" outreach campaign last week, with programming for both physicians and potential patients. Eight action teams across the state are giving presentations about the law to senior centers, colleges and other locations to make sure potential patients understand their rights. A medical provider advocate team, comprised mostly of physicians, is offering education and technical assistance to doctors and medical facilities across the state. The group has also developed print and

online resources, videos, mailers and a series of webinars to help get the word out.

“We are trying to ensure that not only do we have a law in Colorado, but that people have access to that law,” said West. “We need to normalize it and integrate it into the standard of care.”

Hospitals, hospices and health care centers can opt out of the law, and individual care providers may choose not to participate even if their hospitals do.

WHAT IS THE DIFFERENCE BETWEEN AID-IN-DYING, PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA?

For the most part, the different terms reflect the groups who use them.

In developing the 2016 ballot measure, proponents used “medical aid-in-dying” to describe the process of patients self-administering prescribed medication to induce a peaceful death.

Opponents to Proposition 106, such as disability rights activists and groups affiliated with the Catholic Church, tend to use the term “assisted suicide,” arguing that “aid-in-dying” is a euphemism that inaccurately describes the process.

“Euthanasia” is the process by which a physician administers medication to assist a patient in dying, and is illegal in all 50 states. California’s aid-in-dying measure prohibits the practice from being referred to as “euthanasia” or “assisted suicide.”

WHAT’S THE TIMELINE?

Gov. John Hickenlooper signed Proposition 106 into law today.

Requests made starting today cannot be fulfilled immediately, however. To be able to receive aid-in-dying medication, patients must make verbal requests to two different physicians, including their primary care physician, at least 15 days apart. Both physicians must diagnose the patient as terminally ill, observe mental capability and evaluate that the patient is not being coerced into requesting the medication.

Still, said Compassion & Choice's West, physicians need to be proactive in their preparation: "We tell providers that if you start to think about this only when your patient requests it, it's too late."

WHAT KIND OF DRUGS ARE USED, AND WHAT DO THEY COST?

In medical literature, the two most commonly cited drugs for the purposes of aid-in-dying are Nembutal (known generically as pentobarbital) and Seconal (known generically as secobarbital).

Pentobarbital, a barbiturate, was an effective and inexpensive aid-in-dying drug for many years. However, its use as a lethal injection drug for executions recently prompted manufacturers to stop producing it for the United States. Access is now extremely limited, even for use in hospitals as a sedative.

Seconal, a barbiturate-derivative used for the treatment of epilepsy, insomnia and as an anesthetic for minor surgical procedures, is still routinely prescribed to patients seeking a painless, voluntary death. But after California passed aid-in-dying earlier this year, the drug's manufacturer, Valeant Pharmaceuticals, took advantage of the new market and doubled the price. A lethal dose of Seconal now costs $3,000, a price that many people on fixed incomes find prohibitive. In 2009, the same dose cost only $200. There currently is no generic version of Seconal available in the U.S.

Other aid-in-dying drugs exist, but are less commonly prescribed. To combat high prices, doctors have discovered a new drug cocktail that they say works just as well — and retails for only $500. A team of physicians from aid-in-dying advocacy group Doctors with the End of Life developed a mix of three drugs — phenobarbital, chloral hydrate, and morphine sulfate — which are mixed in powdered form and taken with water, alcohol or juice.

This medication is, according to Compassion & Choices' West, "the most affordable and available," but it is only available from compounding pharmacies, which are more rare.

Still, West is optimistic about the range of available drugs, and insists that “there is no problem getting them.”

DOES INSURANCE COVER THE DRUGS?

Colorado’s new law doesn’t require insurance companies to cover aid-in-dying medication. Compassion & Choices’ West said most insurance companies do cover the drug, especially now that California has passed a law, but there’s no guarantee.

A patient’s decision to request aid-in-dying medication will have no effect on annuities, advanced medical directives or health, accident or life insurance policies. Physicians must list the patient’s terminal illness as the cause of death on the death certificate.

DO DOCTORS NEED ADDITIONAL TRAINING?

No. Licensed physicians in Colorado need no additional training or certification to prescribe aid-in-dying medication or to serve as consulting physicians.

Physicians are required to make a record any time an individual requests the medication, documenting that the patient is terminally ill, has six months or fewer to live, was not coerced into requesting the medication and is in good mental health. According to the law, the primary physician must provide “full and specific information to the individual about his or her diagnosis and prognosis; alternatives or additional treatment opportunities, such as hospice or palliative care; and the potential risks and probable results associated with taking the medication.”

Doctors must also inform each patient that he or she may choose not to use the medication, even if it is prescribed, and may withdraw his or her request at any time. If either the primary or consulting physician feels a patient is not mentally capable of making an informed decision about receiving the medication, they must refer the patient to a licensed psychiatrist or psychologist,

who must deem the patient mentally competent before the request process may proceed.

Compassion and Choices' West said that physicians must be licensed and have primary responsibility for a patient's terminal illness. In other words, she said, "a podiatrist would not qualify." For the most part, she said, it has mostly been family practitioners who prescribe the medication in Oregon, along with some oncologists and some hospice medical directors.

WHO WILL OFFER IT?

It's still too early to tell how many hospitals and physicians will participate in providing aid-in-dying to Coloradans.

According to Amber Burkhart, a policy analyst for the Colorado Hospital Association, healthcare facilities must decide whether to opt in or out of the law, and establish policies to go along with their position. Within those policies, individual physicians can always decide to opt out of participating.

Compassion & Choices has sent out mailers to inform physicians and hospitals of the new law, and ensure that they feel prepared to offer aid-in-dying if they so choose. The organization also plans to develop a "Find Care Tool" on their website, which will allow interested patients to find the nearest facilities that honor the right to aid-in-dying under the law.

"When people are thinking about getting a doctor or getting insurance, they will have the information they need to choose healthcare providers who will honor their decisions," said Burkhart.

But the Colorado Hospital Association "does not have a position and neither encourages nor discourages" healthcare providers to provide aid-in-dying, said Burkhart. "We're just focused on providing support," she said.

Sonja Hix-Cortina, a spokeswoman for the Home Care Association of Colorado, said last week that the board was still discussing the issue and hadn't formalized a policy for the association yet.

WHAT ABOUT THE CATHOLIC CHURCH?

Though it's too early to tell how many physicians will provide aid-in-dying, hospitals, physicians and hospice centers affiliated with the Catholic Church will almost certainly not participate.

Catholic hospitals follow the Ethical and Religious Directives for Catholic Health Care Services, a set of rules put out by the U.S. Conference on Catholic Bishops that guides care for affiliated hospitals. The directives, which call medical aid-in-dying "intrinsically immoral," say that "Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death."

Michael Romano, the national media relations director for Catholic Health Initiatives, isn't ready to give a statement about participation in medical aid-in-dying, but said *The Colorado Independent* should read between the lines. The Catholic Health Initiatives website states that affiliated hospitals and health centers must follow the church directives. "Clearly, if Catholic Health Initiatives follows the directives, we're not going to be doing assisted suicide," Romero said last week.

According to the American Civil Liberties Union's 2016 report, "Growth of Catholic hospitals and health systems," between 30 and 39 percent of acute care beds in Colorado are in facilities that are Catholic owned or affiliated.

IS THE BATTLE OVER AID-IN-DYING FINALLY OVER?

Though aid-in-dying passed nearly 2-to-1 in Colorado, the controversy surrounding it rages on. And opposition doesn't just come from the Catholic Church — disability rights activists and physicians who simply disagree with the practice have spoken out against it. In California, some groups even filed a lawsuit looking to overturn the aid-in-dying law.

Though there is no evidence yet as to whether Colorado will see similar lawsuits, opponents continue to make their voices

heard.

Dr. Bill Bolthouse, a physician at a Denver health clinic that primarily serves low-income patients, said his arguments have nothing to do with religion. “I’m not Catholic, but on this side of things I guess we’re on the same team,” he said. To him, aid-in-dying is a violation of the Hippocratic oath, in which doctors promise to do no harm to their patients.

Bolthouse also sees it as “dangerous for people on the margins,” whom he often treats at the health center. He worries that people without financial resources will see aid-in-dying as a cheap alternative to costly treatments.

Dr. Thomas Perille, a retired physician who worked as an internist for 20 years, also opposes the new law. He fears aid-in-dying will become a slippery slope, with doctors developing a tendency to encourage aid in dying for increasingly vulnerable populations. They could, he worries, begin to “resort to euthanasia instead of providing care.”

It’s hard to imagine a doctor suggesting aid-in-dying over treatment, but Bolthouse said change could be on the horizon. “If Medicaid says, ‘Well that treatment is experimental or that treatment is too expensive, we’re not going to pay for it, but we will pay for your life-ending medication,’ it kind of justifies not paying for something expensive,” he said.

Bolthouse referenced a case in 2008 of a woman named Barbara Wagner, who received a letter from her insurance company denying coverage for a new cancer treatment on the ground that it was experimental. Aid-in-dying, however, was listed in the letter as one of the treatments which the insurance company would cover in full.

Wagner ultimately received the treatment she sought, but the incident prompted California to include a provision in its law that insurance companies cannot tell patients who aren’t requesting aid-in-dying medication whether or not they cover the cost. Colorado’s new law doesn’t contain that specific provision, but it does prohibit insurance companies from refusing any treatment based on the availability of aid-in-dying medication.

Bolthouse also said the rise of aid-in-dying demonstrates a deteriorating relationship between doctors and patients. “I think as doctors become more distant from their patients, as we hide behind our screens in clinical situations, we stop touching our patients, we stop looking them in the eye, we stop treating them like human beings,” he said. “It’s not medicine. I don’t know what it is, but its not medicine.”

Dr. Cory Carroll, a physician with a private practice in Fort Collins, wholeheartedly supports medical aid-in-dying. He doesn’t think doctors should be able to make decisions on behalf of their patients, saying instead that, like the separation of church and state, “there should be a separation between church and medicine.” Carroll understands why people oppose aid-in-dying, but believes each patient should be able to make their own choices. “People can look at this as being wrong and immoral, but is it something criminal that should be denied?”

Carroll also thinks aid-in-dying will help close the gap between the humane way that medical professionals tend to die, and the prolonged suffering patients often endure in an attempt to live longer.

“What I do know is how physicians die, and the reason why is that we know what it looks like,” he said. “We don’t go to extraordinary measures to keep our bodies alive.”

Perille disagrees. “I’m quite aware of what the limitations of medical interventions are, and I don’t have any desire to be on a ventilator or chemotherapy with a low percentage chance of working,” he said. “But that doesn’t mean I want to kill myself.”

Calling aid-in-dying “false compassion,” Perille said people may request medication when there are other, solvable problems at play, like pain or depression. “There are people that I’ve met that have terminal illnesses who will tell me they want to die, and then you address the issues that cause them to feel that way, and months later they have a much different perspective,” he said.

But that argument falls flat with Carroll, who said he has seen what happens when his patients can’t access the aid-in-dying they’re looking for.

"As a physician of 25 years, I've had many many patients ask me to help them die," he said. "Some have been successful — with bullets."

1. The author discusses the ways in which the language around assisted suicide affects how people viewed the measure when it was put on the ballot in Colorado. Do you think "medical aid-in-dying" sounds different from "assisted suicide"? If you didn't know what assisted suicide was, do you think the word choice would change how you vote?

2. According to the law signed in Colorado, insurance companies are not required to cover the medication used in assisted suicide. Based on what you've read in this article and in the previous chapter, do you think this will affect who chooses to utilize aid-in-dying services? Explain.

"MEDICAL ASSISTANCE IN DYING: LESSONS FOR AUSTRALIA FROM CANADA," BY JOCELYN DOWNIE, FROM *QUT LAW REVIEW,* VOL. 17, ISSUE 1, OCTOBER 13, 2017

I INTRODUCTION

Canada has recently witnessed dramatic changes in end of life law and policy. Most notably, we have moved from a prohibitive to a permissive regime with respect to medical assistance in dying

(MAiD). As a number of Australian states are actively engaged in debates about whether to decriminalise MAiD,[1] it is worth reviewing the Canadian experience and drawing out any lessons that might usefully inform the current processes in Australia.

II MEDICAL ASSISTANCE IN DYING IN CANADA (VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE)[2]

A THE PAST

Until 2016, assisted suicide was clearly illegal in Canada. It was an offence under s 241(b) of Canada's *Criminal Code*.[3] Euthanasia was also clearly illegal in Canada—it was murder under the *Criminal Code*.[4] In the early 1990s, Sue Rodriguez, a woman with amyotrophic lateral sclerosis (ALS, a degenerative neurological condition), challenged the prohibitions under the *Canadian Charter of Rights and Freedoms* ('Charter'),[5] but was unsuccessful at the Supreme Court of Canada (by the merest 5–4 margin).[6] Over the years, there were a number of failed attempts made to pass legislation that would permit some assisted dying.[7] There was also a Special Senate Committee on Euthanasia and Assisted Suicide, but it too did not end up recommending changes to the law.[8] However, for decades, there was strong majority public support for the decriminalisation of assisted dying.[9] There was also a growing body of evidence from permissive regimes demonstrating that the feared slippery slopes had not materialised.[10] Additionally, there were significant new decisions from the Supreme Court of Canada on various sections of the *Charter* (for example, introducing new 'principles of fundamental justice' and thereby opening up the possibility of new arguments to be made in court that were not available at the time of *Rodriguez*).[11] Finally, an Expert Panel of the Royal Society of

Canada on End of Life Decision-Making recommended the decriminalisation of assisted dying.[12]

B THREE RECENT DEVELOPMENTS

Against this historical backdrop, dramatic reform came in the shape of three major developments. Quebec introduced legislation to regulate medical aid in dying,[13] the Supreme Court of Canada ruled that the *Criminal Code* prohibitions on physician-assisted dying violate the *Charter*,[14] and the federal Parliament passed legislation to establish a federal regulatory framework for MAiD.[15]

1 QUEBEC'S LEGISLATION

The first development hailed from Quebec. On 12 June 2013, following a truly extraordinary process of expert and public consultation,[16] the Quebec government introduced *An Act Respecting End-of-life Care* ('the Act') to allow medical aid in dying.[17] After some skirmishes in court, the legislation came into force in December 2015.[18] The Act establishes a right to 'end-of-life care', defined as 'palliative care provided to end-of-life patients and medical aid in dying'.[19] Under the legislation, 'medical aid in dying' is defined as: 'care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death'.[20]

The Act permits medical aid in dying for patients who meet all of the following criteria, i.e the patient:

(1) is an insured person within the meaning of the Health Insurance Act;

(2) is of full age and capable of giving consent to care;

(3) is at the end of life;

(4) suffers from an incurable serious illness;

(5) suffers from an advanced state of irreversible decline in capability; and

(6) suffers from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.[21]

Considerable safeguards are built into the legislation. These include:

- The patients must meet the criteria for access outlined above;
- The patient must request medical aid in dying themselves, in a free and informed manner;[22]
- Only physicians may provide medical aid in dying;[23]
- Physicians must ensure provision of information, confirmation of conditions being met, second independent opinion, and recording of all information;[24]
- Physicians must report medical aid in dying;[25]
- Institutions must report on continuous palliative sedation and medical aid in dying;[26]
- Inspection powers;[27] and
- Oversight by a Commission sur les soins de fin de vie [Commission on end-of-life care].[28]

In an effort to protect access to medical aid in dying and respect conscience, the legislation requires:

- Physicians who object to medical aid in dying must report requests for medical aid in dying to the executive director (or designate) of their institution (if they work in a public institution) or the local authority (if they work in a private facility) or the local community centre (if the patient lives somewhere with no local authority). The executive director must then find an alternative physician for the patient who has made the request.[29]
- Institutions must offer medical aid in dying unless they offer only palliative care (in which case they may opt out).[30]

Between December 2015 and June 2016, there were 253 requests made for medical aid in dying and 166 cases in which it had been administered. Reasons for requests not (yet) resulting in administration include: the person did not meet the criteria at the time of making the request (27); the person did not meet the criteria during the assessment process or when administration was set to take place (9); the person withdrew the request (24); the person died prior to the scheduled administration (21); the evaluation was still pending (5); and the person rescheduled the administration (1).[31] Between June and December 2016, the number of requests for MAiD increased to 468 and 295 patients received it; as of 31 December 2016, a total of 461 patients were granted MAiD of the 721 who requested it.[32]

2 CARTER V CANADA (ATTORNEY GENERAL)

The second development was *Carter v Canada (Attorney General) ('Carter')*.[33] Kay Carter was a woman with an extremely painful degenerative condition (spinal stenosis) who decided her suffering had become too much; she asked her family to take her to Switzerland for an assisted suicide. They did, and they also became the first named plaintiffs in the case that would change the law in Canada. Then, Gloria Taylor, a woman with amyotrophic lateral sclerosis ('ALS') who wanted an assisted death, joined the case and the British Columbia Civil Liberties Association, representing suffering Canadians more generally, effectively carried the case.

The plaintiffs argued that the *Criminal Code* prohibitions on assisted suicide and voluntary euthanasia violate ss 7 and 15 of the *Charter*.[34] The plaintiffs were successful at trial,[35] lost the appeal (but only on the issue of *stare decisis* — whether the trial judge was bound by the 1993 Supreme Court of Canada decision in *Rodriguez)*,[36] but were then successful again at the Supreme Court of Canada,[37] which ruled 9-0 that the Criminal Code prohibitions violated the Charter and were void. The Supreme Court found that the prohibitions on physician-assisted dying[38]

violated s 7 as they limited the right to life, liberty, and security of the person and were overly broad.[39] The limit on s 7 rights was not saved by s 1 as the prohibitions did not minimally impair the right.[40] Therefore, the prohibitions were void:

> insofar as they prohibit physician-assisted death for 'a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability that causes enduring suffering that it intolerable to the individual in the circumstances of his or her condition'. 'Irremediable', [they added] …, does not require the patient to undertake treatments that are not acceptable to the individual.[41]

The Supreme Court made no comment on whether health care institutions could decline to provide physicianassisted dying. The court commented on, but did not resolve the issue of conscientiously objecting providers:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95–96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.[42]

The Supreme Court suspended their declaration of invalidity for 12 months (to February 2016) to give the government time to craft new legislation should they wish to do so.[43] There was a federal election after the *Carter* decision was released and

subsequently a change in government. When the new Liberal government took office in November 2016, they asked for an extension on the suspension of the declaration of invalidity and were given four months (to 6 June 2016).[44] The Supreme Court also made provisions for individuals to be able to access physician-assisted dying through the courts during the period of the extension. These cases followed the *Carter* criteria and there were 17 reported cases of people accessing physician- assisted dying in that way.[45]

The Supreme Court's decision ultimately took effect 6 June 2016, and, until the new federal legislation was passed (see below), the *Criminal Code* no longer prohibited physician-assisted dying where the *Carter* criteria were met.

Before moving on to the final development in this area, it is worth returning briefly to the trial decision in *Carter*. In her decision, Justice Lynn Smith made a number of important findings of fact (these are important as they were settled at trial and, as is most commonly the case, not unsettled by the Supreme Court of Canada). It is important to repeat them here, as they are the factual foundation for the current Canadian legal framework for medical assistance in dying.

On palliative care, Justice Smith found:

> Adequate palliative care can reduce requests for euthanasia or lead to their retraction.[46]
>
> However, despite the best possible palliative care, some patients suffer pain that cannot be alleviated. … As well, symptoms can cause suffering other than pain (such as nausea, vomiting, and shortness of breath) that cannot be alleviated even by the best palliative care.[47]
>
> Further, high quality palliative care is far from universally available in Canada.[48]

On ethics, she found:

> The preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted

death and other end-of-life practices whose outcome is highly likely to be death.[49]

On the slippery-slope arguments, she found:

[T]he research does not clearly show either a negative or positive impact in permissive jurisdictions on the availability of palliative care or the physician-patient relationship.[50]

No evidence of inordinate impact on vulnerable populations. …[51]

Risks (eg, re: ability to make well-informed decisions, freedom from coercion or undue influence, physicians' ability to assess patients' capacity and voluntariness) exist, but they can be largely avoided through carefully-designed, well-monitored safeguards.[52]

A system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully informed persons acting voluntarily to receive physician-assisted death.[53]

3 *FEDERAL LEGISLATION*

As federal, provincial and territorial governments contemplated how to respond to the *Carter* decision, three groups were tasked by various levels of government with studying the question of how best to regulate assisted dying: a Federal Expert Panel on Options for a Legislative Response to *Carter*, appointed by then Prime Minister Stephen Harper; a Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying; and a Special Joint Committee [of the federal House and Senate] on Physician-Assisted Dying. They all issued reports (the latter two with recommendations).[54] The Provincial-Territorial Expert Advisory Group recommended that governments: not have narrower eligibility criteria than those set out in *Carten*, permit access to MAiD for mature minors, individuals whose sole underlying condition is a mental illness,

and those whose requests were made in advance of loss of capacity; and establish a duty to transfer care from conscientiously objecting providers.[55] The Special Joint Committee issued similar recommendations varying only in recommending a two-year delay in the coming into force of the permissive elements regarding mature minors.[56]

Ultimately the federal government introduced Bill C-14 in April 2016.[57] Most notably, the government adopted narrower eligibility criteria than those set out in *Carter* as the Bill did not permit access to MAiD for mature minors and requests made in advance of loss of capacity (at least not yet); and did not establish a duty to transfer care (although, it must be noted, that lies outside their jurisdiction).[58] A furious federal parliamentary debate ensued.[59] Attempts were made through the House of Commons (in Committee and on the floor) to amend the Bill to be less restrictive.[60] They failed.[61] The Senate sent an amended (less restrictive) Bill back to the House,[62] but the House rejected the more permissive amendments.[63] Finally the Senate conceded and passed the House's restrictive Bill.[64]

After its tumultuous ride through the House and Senate, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*[65] was passed and immediately came into force on 17 June 2016. It is worth repeating that the law as passed is narrower than that recommended by the Royal Society of Canada Expert Panel on End of Life Decision-Making,[66] the Provincial-Territorial Expert Advisory Group, the Special Joint Committee, and the amendments sought by the Senate.

The key elements of the federal legislation are as follows:

- Medical assistance in dying is the umbrella term that includes both voluntary euthanasia and assisted suicide.[67] It is defined in the legislation as:

(a) the admininstering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical

practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.[68]

- Recognising the scarcity of physicians in Canada (especially in rural and remote communities) as well as the competencies and accountability of nurse practitioners, both physicians and nurse practitioners are allowed to provide MAiD.[69]
- Recognising that health care is provided in teams and few physicians or nurse practitioners would be acting completely alone and also recognising that some patients would want their loved ones to be the ones to help them at the end, any person is permitted to assist the providers. So pharmacists, nurses, and friends and family members are all permitted to assist.[70]
- Recognising that patients may well ask a whole range of health care providers about assisted dying and that these providers could be very appropriate sources of information, information can be provided by social workers, psychologists, psychiatrists, therapists, medical practitioners, nurse practitioners, and other health care professionals.[71]

According to s 241.2(1) of the new legislation, only those who meet the following criteria can have access to medical assistance in dying. Patients must:

- be eligible for health services funded by government in Canada (or would be, but for a minimum period of residence or waiting period);
- be at least 18 years old;
- be capable of making decisions with respect to their health;
- have made a voluntary request;
- have given informed consent to receive medical assistance in dying after having been informed of means available to relieve suffering, including palliative care; and have a grievous and irremediable medical condition.

This is further explained in s 241.2(2) as:

- they have a serious and incurable illness, disease or disability;
- they are in an advanced state of irreversible decline in capability;
- that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

The following procedural safeguards must also be met:

- A medical practitioner or nurse practitioner must be of the opinion that the person meets all of the eligibility criteria;[72]
- A request must be made in writing, signed and dated after the patient has been informed of their grievous and irremediable condition;[73]
- There must be two independent witnesses to the request;[74]
- A second independent medical practitioner or nurse practitioner must confirm that the eligibility criteria have been met;[75]
- There must be a 10-day waiting period between the day the request was signed and the day MAiD is provided (unless death or loss of capacity is imminent);[76] and
- The patient must be given the opportunity to withdraw consent and, indeed, must explicitly reconfirm the consent required immediately before MAiD is provided.[77]

Freedom of conscience was, of course, the subject of enormous debate in relation to the legislation. Some health care providers want to be able to opt out of MAiD entirely (including not providing information, transfers of care, or referrals to willing providers) and some institutions want to be able to opt out of allowing MAiD within their walls.[78] Patients and patient advocates in turn worry

about lack of access if opting out is allowed. The legislation itself does not resolve this conflict as it says only the following: ‘nothing in this Act affects the guarantee of freedom of conscience and religion’;[79] and ‘nothing in this section compels an individual to provide or assist in providing medical assistance in dying’.[80]

The legislation also establishes the foundation for retrospective oversight as providers have a duty to file information on every written request for MAiD[81] (once the conditions for coming into force are met), there are penalties for non-compliance with the legislation,[82] and there will be a Parliamentary review of the provisions of Act and the state of palliative care in Canada, scheduled to start on 18 June 2021.[83]

The legislation also imposes some obligations on the Minister of Health as she must make regulations regarding provision, collection, analysis, and reporting of data,[84] and, after consultation with provinces and territories, she must establish guidelines on information to be included on death certificates.[85] The legislation also provides that the Ministers of Justice and Health must initiate one or more independent reviews of issues relating to mature minors, advance requests, and requests where mental illness is the sole underlying condition.[86] In addition, no more than two years after the initiation of the reviews (ie, by 14 December 2018), they must present one or more reports on the reviews to both Houses of Parliament.[87]

Finally, while not in the legislation itself, the federal government also promised to increase support for palliative and end of life care, and to work with the provinces and territories to establish a pan-Canadian system for access, a) to facilitate transfers of care; b) to protect the conscience of objecting providers; and c) to protect the privacy of willing providers.[88]

Despite the passage of the federal legislation, there remain some challenges: first, implementing the legislation; and, second, dealing with several outstanding legal issues. The implementation challenges include: gathering data (eg, standardizing what goes on medical certificates of death[89] and determining what information needs to be reported and to whom[90]); establishing

MAiD protocols (eg, what drugs, dosages, etc.); ensuring that the most appropriate drugs for MAiD are available in Canada;[91] determining who pays for the drugs and the services of the health care providers; managing the promised system for transfers of care in the face of conscientious objections; and educating health care professionals, lawyers, and the public. The key outstanding legal issues to be resolved are conscientious objection and the eligibility criteria.

Federal, provincial and territorial governments, and regulatory bodies will be challenged to clarify whether health care providers have a legal obligation to inform patients about MAiD, transfer care to a provider willing to conduct an assessment and provide assistance to a patient if eligible, and/or arrange an effective referral to a willing provider. The battlegrounds for these issues will be health professional regulatory bodies revising their guidelines and provincial and territorial governments deciding whether to introduce legislation to create statutory obligations for providers.[92] Litigation has already started as the Ontario College of Physicians and Surgeons Guidelines establishing a duty of effective referral are being challenged by a consortium of religious groups.[93] Federal, provincial and territorial governments will also be challenged to clarify whether publicly funded health care institutions have a legal duty to transfer patients, allow the provision of MAiD within their walls, or provide MAiD. Provincial and territorial governments will have to decide whether to insist upon provision by institutions (eg, through legislation,[94] their memoranda of understanding, or funding agreements). Patients may in turn litigate if it turns out that access is being severely hampered by claims of freedom of conscience by institutions. It seems increasingly likely that this will be an ongoing and growing source of friction as a significant number of institutions appear to be opting out without facing any consequences from the provinces or territories.[95]

The federal Parliament must also deal with outstanding issues concerning the eligibility criteria. As noted earlier, Parliament decided to exclude but undertake further study on issues of

mature minors and requests made in advance of loss of capacity.[96] As required by the legislation, between now and December 2018, there are independent reviews of the questions of mature minors, advance requests, and mental illness as the sole underlying condition. Advocates on all sides of these issues will ultimately attempt to persuade Parliament to ensure that the legislation reflects their positions on these issues.

The Parliament also decided to exclude, with no promise of further study, those whose conditions are 'incurable', who are in an 'advanced state of irreversible decline in capability', and whose 'natural death' has become 'reasonably foreseeable'. There will be two kinds of challenges to these criteria. First, there will be cases questioning what the key terms or phrases mean. For example, in *AB v Canada (Attorney General)*, a woman sought clarification of the meaning of 'reasonably foreseeable'.[97] Second, there will also be *Charter* challenges to the exclusion criteria. In particular, there will be challenges to the requirements that the patient's condition must be incurable, the patient must be in an advanced state of irreversible decline in capability, and their natural death must have become reasonably foreseeable. Recall that the Supreme Court of Canada, in one voice, declared the *Criminal Code* prohibitions on MAiD void because they violated the *Charter* insofar as they prohibited physician-assisted death for:

> a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable', [they added] …, does not require the patient to undertake treatments that are not acceptable to the individual.[98]

Contrast this with the federal legislation. There is no reference to 'incurable' in the *Carter case* declaration. There is no reference to 'advanced state of irreversible decline in capability' in the *Carter* declaration. There is no reference to 'reasonably foreseeable' in the *Carter* declaration. In sum, the following

hypothetical people would be allowed access to MAiD through the *Carter* declaration and, as is already being argued, the *Charter* would require them to have access, but they would be denied access by the legislation: someone who has had three unsuccessful rounds of chemo and is refusing a fourth (if her disease is not considered incurable);[99] someone who had a traumatic injury five years ago (as there is no decline in capability); someone with Chronic Obstructive Pulmonary Disease (as death is too uncertain); someone with Parkinson's Disease, ALS, multiple sclerosis, or Huntington's disease (when death is too far off); and even someone in Kay Carter's situation, who is only 60 instead of 89 (as death is too far off).

One *Charter* challenge to the new legislation was launched in *Lamb v Canada (Attorney General)*[100]—by the same legal team that argued and won the *Carter* case. Julia Lamb is a 25- year-old woman with spinal muscular atrophy. This is a degenerative muscle-wasting condition that is slowly depriving Julia of a wide range of muscular functions and, consequently causing considering pain and suffering. She does not wish to access MAiD now, but can anticipate a time at which she would find her suffering to be enduring and intolerable; however, her physicians would not be able to predict with sufficient certainty that her death is reasonably foreseeable. She is arguing that the new federal legislation violates her s 7 and s 15 rights under the *Charter*. This case will focus on Julia and other people who, the Supreme Court of Canada said in *Carter*, must not be prevented from having access to MAiD, but who do not have access under the federal legislation.

A second *Charter* challenge, *Jean Truchon and Nicole Gladu v Attorney General (Canada) and Attorney General (Quebec)*,[101] has been launched arguing that both the federal and Quebec laws are too restrictive. Jean Truchon has cerebral palsy, and Nicole Gladu, has post polio syndrome.

Governments and practitioners are also going to have to wrestle with the on-the-ground consequences of some of the

provisions in the federal legislation. These include (but are not limited to):

- A patient is in agony from spinal stenosis but refuses pain medication at dosages sufficient to control the pain, in order to be competent at the time of the request and at the time of provision of MAiD.[102]
- A patient has advanced bone cancer pain that can be managed by such deep sedation that she is in a semi-conscious state. She has her sedation lightened (and is thereby returned to a state of experiencing severe pain) so that she will regain capacity at the time of provision of MAiD.[103]
- A patient has completed all of the requirements (including the 10-day waiting period) on a Friday afternoon, her MAiD provider is not available until Monday, she loses capacity on the weekend, and so becomes ineligible for MAiD and remains stranded in a state of enduring and intolerable suffering until she dies from her underlying condition months later.[104]
- A patient was diagnosed with Alzheimer's disease three years ago and made an advance request for MAiD and, if that wasn't available, an advance directive refusing all oral hydration and nutrition once she reached stage seven of the disease. She is now stage seven, incapable and therefore ineligible for MAiD, and so the institution stops giving her food and liquids and waits while she dies of dehydration.[105]
- A patient has multiple sclerosis but, although experiencing enduring and intolerable suffering, her death is not reasonably foreseeable. She decides to stop eating and reduce liquids in order to get close enough to death to qualify for MAiD while still retaining capacity. It takes 50 days without food and four days without liquid before her physician determines that she meets the eligibility criteria.[106]
- A patient has Huntington's disease and while experiencing enduring and intolerable suffering, her death is not likely for a number of years. She asks her physician to provide her with deep and continuous sedation and she refuses artificial hydration and nutrition. She dies 14 days later.[107]

As the public continues to learn of these situations that result from the way in which the legislation has been drafted, there is likely to be increased pressure on governments to revisit the provisions that create such situations and on providers to find ways to avoid the consequences while respecting the provisions.[108]

Finally, the inconsistencies between the Quebec legislation, the *Carter* decision, and the federal legislation will need to be addressed. For example, the Quebec legislation requires that patients be 'at the end of life', which is a much narrower criterion than *Carter's* criterion of 'grievous and irremediable condition'. The federal legislation also requires a 10-day waiting period between the request and the provision of MAiD while the Quebec legislation does not.[109]

III LESSONS FOR AUSTRALIA

What then can Australia learn from the Canadian experience with decriminalising medical assistance in dying? First, ***be patient and adaptable.*** In Canada, advocates of law reform concurrently worked on litigation, legislation, and prosecutorial charging guidelines.[110] They wanted to be able to go through any crack in any window of opportunity that opened. If one waits for the window to open before developing the arguments, drafting legislation, etc, then by the time the work is done, the window will have closed again. So the advocates prepared for all eventualities, were patient, and then took the litigation path when it opened and the legislation path when that followed.

Second, ***prepare the foundations for law reform initiatives.*** It was essential to the plaintiffs' success in the *Carter* case that they were able to access robust empirical evidence on the experience with assisted dying around the world[111] as well as well-developed legal and ethical arguments on why assisted dying should be decriminalised.[112] Very clear strong public support for both the *Carter* decision and assisted dying were also important for the legislative process.[113]

Third, ***consult and engage broadly.*** As noted earlier in this paper, this principle was embraced by the Quebec Select Committee on Dying with Dignity and is in no small part a reason for the widespread support for their medical aid in dying legislation. It was also respected (albeit on an abridged timeline) by the Provincial–Territorial Expert Advisory Group on Physician-Assisted Dying and the Special Joint Committee on Physician-Assisted Dying and, again, probably played a role in the strong positive response their reports received from the majority of Canadians. However, the perils of not consulting were also manifest in the Canadian process. For example, the Canadian government did not consult with the regulators of physicians, but rather just consulted with the Canadian Medical Association.[114] If they had consulted with those who are tasked with regulating physicians, they would have been advised not to use the criterion that 'natural death' be 'reasonably foreseeable'[115] and, had they followed that advice, they would have avoided the firestorm that greeted their draft legislation and the *Charter* challenge to the legislation that has now been commenced.[116]

It is also essential to be *respectful of heterogeneity in communities*. The loudest voice does not necessarily articulate the most widely held or only held position. A good example of this phenomenon in Canada is with respect to persons with disabilities. There was a very vocal group representing persons with disabilities and arguing for as restrictive an approach as possible.[117] Yet there are many other people with disabilities who believe that the most restrictive approach is patronising, paternalistic, and infantilising.[118]

Remember also to *consult with indigenous communities*. In Canada, indigenous communities lack access to health services, are confronting a higher rate of suicide than non-indigenous populations, and have a range of different cultural values and beliefs relevant to end of life decision-making.[119] In Canada, they were not adequately engaged in the conversations about decriminalisation and implementation of MAiD.[120] As a result,

policy-makers and providers are now playing catch-up and trying to undo misinformation and mistrust.

Fourth, ***prepare the infrastructure for assisted dying.*** It is essential to develop a mechanism for identifying willing providers, as providers can feel at risk of stigmatisation by their colleagues and attack from opponents of assisted dying, and so may not make their willingness known. But, in order to ensure access for patients, it is essential to know who and where the willing providers are. Some physicians in Canada have been very open about being willing providers.[121] Some provinces and territories have set up a central team that can be contacted by patients.[122] Access is further enhanced if some entity capable of protecting provider privacy is given the mandate and resources necessary to act as a go-between to ensure patients have access to willing providers.[123] It is also essential to develop a transfer of care system if any conscientious objection by providers and/or publicly funded health care institutions will be permitted. Many provinces and territories in Canada have set up such systems and as a result some patients can access MAiD even when their own health care providers object to it.[124]

It is also necessary to make sure the most appropriate drugs are licensed. It was only realised after the fact that secobarbital (the drug preferred by Canadian providers, for self-administered MAiD) is not available in Canada, so patients who wish to self-administer may face real barriers to doing so (for example, an oral protocol is available in Alberta but not in Nova Scotia).[125] Australian patients could find themselves in the same bind if the barriers to access to secobarbital (or pentobarbital which may be preferred in Australia) are not removed when or before MAiD is decriminalised.

It is also important to establish educational programs for health professionals, lawyers, and the public. Everyone needs to understand what the law is and what their rights and obligations are, and providers need to know how to deliver MAiD. Support systems must also have been put in place for providers as well as patients and families. Canada is playing catch-up on both of these

infrastructure pieces—MAiD is legal but not everybody has the information or support they need.[126]

It is also essential to establish the infrastructure for the oversight system: for the sake of accountability, transparency and trust, all cases should be reviewed; and death certificate forms need to be modified and instructions given on the completion of death certificates (what is the manner of death, the underlying cause of death, etc).[127] These steps enable robust data gathering, analysis and reporting, which again is essential for accountability and transparency, and having and deserving the trust of the public. They also enable research to be conducted on a range of issues aimed at improving end of life care. Unfortunately, Canada did not get its oversight infrastructure in place prior to the legalisation of MAiD. Indeed, more than a year after the legislation came into force, there is no pan-Canadian oversight system; there is considerable variability with respect to who is conducting case reviews (where any case review is being done), and there is no standard approach to what information is being reported and to whom. Even the death certificate forms and instructions are not consistent across the country.[128]

More positive lessons can be learned from other permissive jurisdictions, for example, the Netherlands and Belgium have robust systems for reviewing and reporting on all cases and the Netherlands, Belgium, and the permissive American states all gather and report on robust data sets.[129] The Netherlands also commissions a major end of life decision-making research study every five years rather than (as in Belgium) leaving this to researchers to find their own funding independently (and therefore somewhat irregularly).[130] However, nobody yet has developed a system that gathers reliable data on all requests (which can provide important evidence on a variety of issues such as patient access) or that facilitates research in an efficient, reliable, and cost-effective manner (eg, by linking MAiD cases through death certificates with large health information databases). Again, while these issues were flagged for the Canadian authorities, they did

not get out ahead of them and so we are in a sense building the ship while sailing it— and this is definitely not ideal.

Fifth, ***beware of negative consequences*** that can accompany particular turns of phrase in legislative drafting and particular positions taken on substantive issues in the debate about criteria for access and procedural safeguards. In particular, as illustrated earlier, there are serious negative consequences flowing from the following elements of the Canadian legislation: capacity required at time of provision; mandatory waiting periods; access limited to those for whom death is 'reasonably foreseeable';[131] and allowing providers and institutions to opt out. This is not to say that legislators must avoid all of these elements (although I would argue for that). Rather, it is to say that legislators must be aware of the consequences of proceeding with those elements. It might be argued that the Canadian government did not know and therefore should not be blamed for the consequences of their legislative drafting. However, any jurisdiction that follows Canada will have been forewarned and will therefore bear the responsibility for the suffering that ensues.

Sixth, take the opportunity of assisted dying being on the legislative agenda to also ***address related end of life issues.*** The Canadian legislation only deals with MAiD, so it did not resolve the following issues: unilateral withholding or withdrawal of potentially life-sustaining treatment (can a physician withhold or withdraw potentially life-sustaining treatment without the knowledge of or against the wishes of the patient or patient's substitute decision-maker?);[132] palliative sedation (can you provide deep and continuous sedation and respect a refusal of artificial hydration and nutrition for a patient with a neurodegenerative condition who is not expected to die for years but whose suffering has become enduring and intolerable?);[133] and voluntary stopping of eating and drinking (can patients stop eating and drinking until death and can they refuse not only artificial hydration and nutrition but also oral feeding through an advance directive?).[134] End of life decision-making is best seen as a spectrum of care and countries should have clear laws about the

entire spectrum so that they can care best for all patients at the end of life. Canada does not. Australia does not. Yet both countries can and should.

The final lesson to be drawn from the Canadian experience is that ***the hard work that it takes to decriminalise MAiD is worth it.*** Approximately 970 people have been able to access MAiD as of 31 December 2016.[135] Some (a much larger number) will have made a request for MAiD and qualified, but never self-administered or had a physician or nurse practitioner admininster it. An unknown number (but still higher) have been comforted to know that MAiD would or will be available to them, should, or when, they reach the point of enduring and intolerable suffering. Still others (a much, much larger number) will never have made a request but will have been relieved just to know that the option would be there for them to pursue should their suffering ever become enduring and intolerable.

Obviously much still remains to be done in Canada. But these are at least some of the lessons that can be learned so far. My hope is that Australian states can take the good, leave the bad, and thereby profoundly enhance end of life care in Australia.

1. The author of the paper uses the Canadian aid-in-dying legislation to discuss how states in Australia can best craft their own legislation. What are three components of the Canadian law that you think are the most important to be carried over into other countries' right-to-die laws?

2. The Canadian legislation discusses what physicians who don't morally agree with the law should do if a patient requests aid in dying. Do you agree with this part of the law? Explain your thinking.

“CALIFORNIANS NOW HAVE RIGHT TO ‘AID IN DYING’: HOW DID WE GET HERE?,” BY DAVID ORENTLICHER, FROM *THE CONVERSATION,* JUNE 10, 2016

Twenty years ago, no one in the United States could claim a right to “physician aid in dying” (also called “physician-assisted suicide”). Today, more than 52 million Americans can.

On June 9, California became the fifth state to permit its terminally ill residents to obtain a prescription for a lethal dose of medication, as the End of Life Option Act, which the state legislature passed in late 2015, went into effect. Now, with their physicians’ help, patients in California can minimize their suffering at the end of life by hastening their time of death.

Recognition of a right to aid in dying began slowly.

Indeed, early efforts to legalize the practice failed. Residents of Washington state in 1991 and California in 1992 voted against aid in dying when referenda were placed on the ballot. And in 1997, the Supreme Court rejected a constitutional right to aid in dying. While in that same year Oregon became the first state to allow aid in dying, no other state followed suit for more than a decade.

But by 2008, support for aid in dying had grown significantly. Since then, Washington, Montana, Vermont and California have all changed their laws, and we can expect other states to do so in the coming years.

So why have Americans become more receptive to a practice that was rejected throughout the United States until Oregon changed course? Indeed, why did the California legislature pass an aid-in-dying law in 2015 when its voters opposed aid in dying in the 1992 referendum?

LEARNING FROM EXPERIENCE

When aid-in-dying advocates drafted Oregon’s law (first passed in 1994 but delayed by legal challenges until 1997), they made a

number of important changes to the earlier unsuccessful proposals in Washington and California.

In a key departure from those proposals, drafters in Oregon did not include a right to euthanasia, which would have allowed doctors to inject a lethal dose of medication into aid-in-dying patients. While physicians can give their terminally ill patients a prescription for a lethal dose of medication, they cannot administer the dose themselves.

The Oregon law also added several requirements to ensure that patients would make an informed and voluntary choice when they exercised their aid-in-dying right.

For example, rather than simply saying that patients have to repeat their request for aid in dying to their physician, as was proposed in the 1992 California referendum, Oregon requires patients to express their wishes multiple times over a 15-day period.

OTHER STATES LOOKED TO OREGON'S MODEL

Once other states saw that Oregon had developed an aid-in-dying law with strong safeguards and that aid in dying could be implemented without evidence of abuse, a right to aid in dying became more attractive.

Most of the states that have recognized such a right closely follow Oregon's approach. The exception is Montana, where the right to aid in dying resulted from a decision by the state Supreme Court. The court did not include the detailed rules seen in Oregon, Washington, Vermont and California, whose aid-in-dying laws were passed through public referenda or legislative action.

Oregon's track record was especially important for other states. When the U.S. Supreme Court rejected a constitutional right to aid in dying in 1997, the justices observed that many people were worried about the experience with euthanasia in the Netherlands, and there was no experience with aid in dying in the United States to provide reassurance. But later states had a

decade or more of data from Oregon before they enacted their laws.

While the laws include a number of safeguards, three are particularly important. Indeed, all five states that have legalized aid in dying include each of the three safeguards.

1. PATIENTS MUST BE TERMINALLY ILL

Aid in dying is not available until a person has become “terminally ill,” which typically means having a life expectancy of no more than six months, even with aggressive medical care. Thus, in Oregon, almost 80 percent of aid-in-dying patients have a cancer that has become untreatable.

California, Oregon, Vermont and Washington all define terminal illness in terms of a six-month life expectancy, while under Montana aid-in-dying law, one is terminally ill when death is expected “within a relatively short time.”

This stands in contrast to the Netherlands and Belgium, where aid in dying is available to persons who are not terminally ill. In those countries, there is real concern that aid in dying has been used by patients who needed psychological counseling or other treatments that might have restored their desire to continue living.

2. PATIENTS MUST BE MENTALLY COMPETENT ADULTS

Aid in dying is not an option for children, persons with dementia or anyone else who lacks the mental capacity necessary to make medical decisions. Aid-in-dying patients must be able to decide for themselves about their medical care, and they must reaffirm their desire for aid in dying over an extended waiting period. As in Oregon, aid-in-dying laws in California, Washington and Vermont require patients to express their wishes multiple times during a 15-day stretch.

Aid-in-dying laws in those four states also require two physicians to determine that the patient can make medical

decisions, is acting voluntarily and has made an informed choice of aid in dying. In addition, if either physician finds any evidence of a mental disorder, the doctor must refer the patient for evaluation by a mental health specialist. As a result, we have not seen aid in dying in the United States being practiced on patients against their will, without their knowledge or because their families made the choice for them.

3. AID IN DYING IS NOT EUTHANASIA

Critically, aid-in-dying patients must perform the life-ending act themselves. Family members or friends can help prepare the lethal drink (typically the prescription medication dissolved in water), but the patients must ingest the drink on their own. No one can do it for them, nor can physicians or other persons inject a lethal drug into an aid-in-dying patient.

By requiring the patient to perform the life-ending act themselves, states can prevent aid in dying from being performed by someone else without the patient's consent. Whether to bring about death remains under the patient's control until the very end.

Experience elsewhere illustrates the importance of a distinction between aid in dying and euthanasia. Much of the controversy about end-of-life practices in the Netherlands reflects concerns that euthanasia is performed inappropriately on children or adults who cannot make their own medical decisions.

AID IN DYING IS SAFE, LEGAL AND RARE

All of the safeguards have ensured that aid in dying remains a safe and rare event.

After nearly 20 years of legalization in Oregon, aid in dying accounts for less than one-half of one percent of deaths in the state. In addition, aid in dying has not put patients who are minority, uninsured or uneducated at risk. The typical aid-in-dying patient is white, insured and well-educated.

For many patients, a right to aid in dying provides comfort even when not fully exercised. Among patients in Oregon who have received a prescription since 1997, about 35 percent died without taking the medication. Those patients benefited from knowing that they had the option to take the pills if their suffering became intolerable, relieving them of the psychological stress that can accompany the prospect that one's terminal illness will impose even greater suffering.

Allowing aid in dying seems much more like letting seriously ill patients refuse ventilators or other life sustaining treatment than letting depressed persons choose suicide.

Just as usual end-of-life laws allow patients to bring an end to the dying process by declining chemotherapy, dialysis, and feeding tubes, so aid-in-dying laws allow patients to bring an end to the dying process by taking a lethal dose of drugs. But aid-in-dying laws do not extend their rights to people who might want to end their lives because of psychological distress.

With their important safeguards, aid-in-dying laws have helped dying persons minimize their suffering while protecting against a slide down the slippery slope toward abuse.

1. The author discusses the many US laws that regulate assisted suicide. One of the common traits of US death-with-dignity laws is that patients must administer the deadly medication themselves and cannot receive lethal injections or physical assistance in ingesting the medication. Do you think this is an important part of the law? Explain why you would keep this in the law or change it.

2. All of the laws discussed in this chapter require the patient to consent to dying numerous times over an extended period to ensure that they are making

a rational, informed decision. What are the pros and cons of this practice?

CHAPTER 3

WHAT THE COURTS SAY

In the previous chapter you learned about the laws that guide people's right to die in countries around the world as well as here in the United States. Many of the laws that were discussed, however, first came about because of court cases challenging the government's obligation to keep citizens alive. While the laws are now decided, the courts did not have the same kind of precedence the government had when deciding how to write their legislation. As you read the cases in this chapter, you'll see how the laws came about—or didn't— and be asked to think about how you would have responded had you been the judge.

"THE SUPREME COURT OF CANADA RULING IN *CARTER V. CANADA*: A NEW ERA OF END-OF-LIFE CARE FOR CANADIANS" BY HADI KARSOHO, FROM *BIOÉTHIQUE ONLINE*, FEBRUARY 13, 2015

In a unanimous ruling released on February 6, 2015, the Supreme Court of Canada (SCC) found in *Carter v. Canada (Attorney General)* [1] that the federal Criminal Code [2] prohibitions on physician-assisted dying (PAD) to have infringed on Canadians' Charter rights to life, liberty, and security. With this historic judgment, Canada has become the second country in the world, after Colombia, to have allowed for PAD on constitutional grounds.[1] *Carter v. Canada* had its origin with the death of a British Columbia woman, Kay Carter, at the Dignitas assisted suicide clinic in Switzerland. Slightly over a year later, Carter's daughter and son-in-law launched constitutional litigation along with the British Columbia Civil Liberties Association, a family medicine physician, and Gloria Taylor, a woman suffering from Amyotrophic Lateral Sclerosis. In 2012, the trial judge found for the claimants and ruled as unconstitutional the impugned prohibitions, a decision that was later overturned by the B.C. Court of Appeal. The SCC granted the claimants leave to appeal and heard oral arguments on October 15, 2014.

The SCC found sections 241(b)[2] and 14[3] of the Criminal Code to have infringed on Canadians' rights to life, liberty and security of the person guaranteed under section 7 of the Charter of the Rights and Freedoms [3]. The law infringes on the *right to life* insofar as it has the effect of forcing some individuals to take their own lives prematurely for fear that they may be unable to do so at a later time when they will have become disabled or their suffering is too great. The law infringes on the *right to liberty* insofar as it deprives

individuals of the right to make medical decisions concerning their own bodily integrity; and it infringes on the *right to security* because it forces some individuals to endure intolerable suffering. Further, the SCC found the law to be overly broad: the purpose of the law is to protect vulnerable individuals from being induced to commit suicide. The law, however, catches others outside of this group of protected persons – i.e., other non-vulnerable individuals who wish to hasten their own deaths. More importantly, the infringement is not saved by section 1 of the Charter – the Charter provision that allows the state to curtail constitutional rights in the interests of society – because the Court agreed with the trial judge that evidence from Canada and abroad showed there to be less restrictive means to protect vulnerable individuals, other than an absolute prohibition.

Reading media reports published soon after the release of the decision, bioethicists might be forgiven for thinking that this case is concerned only with physician-assisted suicide. Many national and international media refer to assisted suicide in their headlines and bodies of texts when discussing the practice at the heart of this case [4-7]. But make no mistake: the SCC decriminalized both euthanasia *and* physician-assisted suicide, practices that many bioethicists have long recognized to be ethically related but which may be distinguished in practical terms. The American Medical Association's Code of Medical Ethics, for example, defines physician-assisted suicide (PAS) as "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" [8]. Euthanasia is distinguished from PAS in that another person – a physician in places that have legalized euthanasia – administers the life-ending act. Specifically, the SCC decriminalized "physician-assisted death" or "physician-assisted dying" and it accepted the claimants' definition of this term as a "situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient." [1]

The obfuscation in the media may be unintentional; contrary to popular understanding, the terms 'euthanasia' and 'physician-assisted suicide' are not self-explanatory. In the last couple of decades, these terms have evolved to acquire highly technical specificities. They are, in other words, legal and clinical (not to mention ethical) constructs, labels that can be understood only in terms of their legal and clinical enactment at a specific historical juncture. Even one of the SCC justices was initially confused as regards the use and implication of these terms. When I attended the hearing last October, Justice LeBel interrupted the counsel for the claimants early in the proceeding when he asked if "we are discussing strictly assisted suicide, we are not discussing euthanasia this morning?" [9] Further, the SCC may itself be partly to blame for the confusion. In its 85-page decision, the SCC shied away from using the term 'euthanasia'. The one time it used the term substantively was in the context of a discussion of the slippery slope argument: "Finally, it is argued that without an absolute prohibition on assisted dying, Canada will descend the slippery slope into euthanasia and condoned murder." [1]

A careful reading of this paragraph revealed that the SCC had used the term 'euthanasia' much as a bioethicist would use the term '*involuntary* euthanasia', that is, killing someone against their own wishes, or culpable homicide. So it ought to be clear for readers that *Carter v. Canada* has decriminalized both 'physician-assisted suicide' and 'voluntary active euthanasia', as they are conventionally understood in the bioethics literature.

In the aftermath of this decision, what does a Canadian PAD regime look like? Here, it is instructive to recall the distinction between decriminalization and legalization. The SCC has just decriminalized PAD. The only criteria for access to the practice that the SCC specified are: a) being a competent adult; b) having a clear consent; and c) having a diagnosis of a

grievous and irremediable medical condition that causes suffering that is intolerable to the individual. The SCC has thus only set the 'floor' of the regime; the 'ceiling' is to be determined by the federal and provincial governments in terms of the legislation they will enact, should they choose to do so. One intervener exclaimed that the "judgment permits assisted suicide on the basis of psychological suffering." [10] But the SCC specified no such thing; it leaves the *possibility* for such criterion to be articulated by governments in their legislation. So far, Quebec is the only province that has passed a law on PAD, *Bill 52: An Act respecting end-of-life care* [11], set to take effect in December 2015. While Quebec's law will allow for patients with irremediable and unbearable psychological suffering to request medical aid-in-dying, it also stipulates that the patient must be at the end of his or her life.

The issue of inter-jurisdictional immunity was also addressed by the SCC. One of the questions the SCC was asked to consider – a question that was raised only at the SCC level after the passage of Quebec's *Act respecting end-of-life care* – was whether the Criminal Code prohibitions could not apply on the issue of PAD because they encroached on healthcare, a constitutionally protected area of provincial competence. The SCC answered this question in the negative and reaffirmed instead that health "is an area of concurrent jurisdiction, which suggests that aspects of physician-assisted dying must be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation." [1] This finding by the SCC means that the federal government could, in theory, modify the Criminal Code in such a way as to conflict with Quebec's Act, which would then certainly lead to another constitutional battle in the court. I hope the federal government avoids the adversarial route and chooses instead to work with the provincial governments in creating a new legislation, especially to ensure uniformity of the regimes across the country.

The ball is now clearly in the federal government's court. The federal justice minister had promised that the government would "study the decision and ensure all perspectives on this difficult issue are heard." [12] Quebec could provide a model with the public and expert consultation process it conducted leading up to and during the creation of Bill 52. However, that process took five years and the federal government does not have the luxury of time. It therefore ought to work with invested stakeholders such as the Canadian Medical Association and other healthcare professionals' associations in crafting legislation. While individual bioethicists have been active participants in the debate, the Canadian Bioethics Society has been strangely silent. Now that the conversation has shifted to the substance of subsequent legislation, the Canadian Bioethics Society ought to look into ways in which it can contribute meaningfully to this process. I have no doubt that the SCC ruling in *Carter v. Canada* will have ripple effects beyond the borders of this country, much as the legalization of PAD in other jurisdictions has been an important historical condition of possibility for this case.

1. The Supreme Court of Canada found that denying terminally ill patients the right to assisted suicide was actually impeding with their right to life. Based on the court's explanation, do you agree with this ruling? Explain your response.

2. Rather than legalizing physician-assisted suicide, the Supreme Court of Canada merely decriminalized it. Explain the difference between

legalization and decriminalization and discuss why you think the Supreme Court only decriminalized assisted suicide.

EXCERPT FROM *CRUZAN BY CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH (NO. 88-1503)*, FROM THE UNITED STATES SUPREME COURT, JUNE 25, 1990

Chief Justice REHNQUIST delivered the opinion of the Court.

Petitioner Nancy Beth Cruzan was rendered incompetent as a result of severe injuries sustained during an automobile accident. Copetitioners Lester and Joyce Cruzan, Nancy's parents and coguardians, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties. The Supreme Court of Missouri held that, because there was no clear and convincing evidence of Nancy's desire to have life sustaining treatment withdrawn under such circumstances, her parents lacked authority to effectuate such a request. We granted certiorari, 492 U.S. 917 (1989), and now affirm.

On the night of January 11, 1983, Nancy Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and she was transported to a hospital in an unconscious state. An attending neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent brain damage generally results after 6 minutes in an anoxic state; it was estimated that Cruzan was deprived of oxygen from 12 to 14 minutes. She remained in a coma for approximately three weeks, and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. She now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function.[n11] The State of Missouri is bearing the cost of her care.

After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agree that such a removal would cause her death. The employees refused to honor the request without court approval. The parents then sought and received authorization from the state trial court for termination. The court found that a person in Nancy's condition had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of "death prolonging procedures." App. to Pet. for Cert. A99. The court also found that Nancy's expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that, if sick or injured, she would not wish to continue her life unless she could live at least halfway normally suggests that, given her present condition, she would not wish to continue on with her nutrition and hydration.

Id. at A97-A98.

The Supreme Court of Missouri reversed by a divided vote. The court recognized a right to refuse treatment embodied in the common law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case. Cruzan v. Harmon, 760 S.W.2d 408, 416-417 (Mo.1988) (en banc). The court also declined to read a broad right of privacy into the State Constitution which would "support the right of a person to refuse medical treatment in every circumstance," and expressed doubt as to whether such a right existed under the United States Constitution. Id. at 417-418. It then decided that the Missouri Living Will statute, Mo.Rev.Stat. § 459.010 et seq. (1986), embodied a state policy strongly favoring the preservation of life. 760 S.W.2d, at 419-420. The court found that Cruzan's statements to her roommate regarding her desire to live or die under certain conditions were "unreliable for the purpose of determining her intent," id. at 424, "and thus insufficient to support the coguardians claim to exercise substituted judgment on Nancy's behalf." Id. at 426. It rejected the argument that Cruzan's parents were entitled to order the termination of her medical treatment, concluding that no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here.

Id. at 425. The court also expressed its view that "[b]road policy questions bearing on life and death are more properly addressed by representative assemblies" than judicial bodies. Id. at 426.

We granted certiorari to consider the question of whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.

At common law, even the touching of one person by another without consent and without legal justification was a battery. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts § 9, pp. 39-42 (5th ed. 1984). Before the turn of the century, this Court observed that

[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. See Dobbs, Keeton, & Owen, supra, § 32, pp. 189-192; F. Rozovsky, Consent to Treatment, A Practical Guide 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until about 15 years ago and the seminal decision in In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976), the number of right-to-refuse-treatment decisions were relatively few.[n2] Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common law rights of self-determination.[n3] More recently, however, with the advance of medical technology capable of sustaining life well past the point where

natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned. See 760 S.W.2d at 412, n. 4 (collecting 54 reported decisions from 1976-1988).

In the Quinlan case, young Karen Quinlan suffered severe brain damage as the result of anoxia, and entered a persistent vegetative state. Karen's father sought judicial approval to disconnect his daughter's respirator. The New Jersey Supreme Court granted the relief, holding that Karen had a right of privacy grounded in the Federal Constitution to terminate treatment. In re Quinlan, 70 N.J. at 38-42, 355 A.2d at 662-664. Recognizing that this right was not absolute, however, the court balanced it against asserted state interests. Noting that the State's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims," the court concluded that the state interests had to give way in that case. Id. at [p271] 41, 355 A.2d at 664. The court also concluded that the "only practical way" to prevent the loss of Karen's privacy right due to her incompetence was to allow her guardian and family to decide "whether she would exercise it in these circumstances." Ibid.

After Quinlan, however, most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right. See L. Tribe, American Constitutional Law § 15-11, p. 1365 (2d ed. 1988). In Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977), the Supreme Judicial Court of Massachusetts relied on both the right of privacy and the right of informed consent to permit the withholding of chemotherapy from a profoundlyretarded 67-year-old man suffering from leukemia. Id. at 737-738, 370 N.E.2d at 424. Reasoning that an incompetent person retains the same rights as a competent individual "because the value of human dignity extends to both," the court adopted a "substituted judgment" standard whereby courts were to determine what an incompetent individual's decision would have been under the circumstances. Id. at 745, 752-753, 757-758, 370 N.E.2d at 427, 431, 434. Distilling certain state interests from prior case law -- the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession -- the court recognized the first interest as paramount and noted it was greatest when an affliction was curable,as opposed to the State interest where, as here, the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended.

Id. at 742, 370 N.E.2d at 426.

In In re Storar, 52 N.Y.2d 363, 438 N.Y. S.2d 266, 420 N.E.2d 64, cert. denied, 464 U.S. 858 (1981), the New York Court of Appeals declined to base a right to refuse treatment on a constitutional privacy right. Instead, it found such a right "adequately supported" by the informed consent doctrine. Id. at 376-377, 438 N.Y.S.2d at 272, 420 N.E.2d at 70. In In re Eichner (decided with In re Storar, supra), an 83-year-old man who had suffered brain damage from anoxia entered a vegetative state and was thus incompetent to consent to the removal of his respirator. The court, however, found it unnecessary to reach the question of whether his rights could be exercised by others, since it found the evidence clear and convincing from statements made by the patient when competent that he "did not want to be maintained in a vegetative coma by use of a respirator." Id. at 380, 438 N.Y.S.2d at 274, 420 N.E.2d at 72. In the companion Storar case, a 52-year-old man suffering from bladder cancer had been profoundly retarded during most of his life. Implicitly rejecting the approach taken in Saikewicz, supra, the court reasoned that, due to such life-long incompetency, "it is unrealistic to attempt to determine whether he would want to continue potentially life-prolonging treatment if he were competent." 52 N.Y.2d at

380, 438 N.Y.S.2d at 275, 420 N.E.2d at 72. As the evidence showed that the patient's required blood transfusions did not involve excessive pain and, without them, his mental and physical abilities would deteriorate, the court concluded that it should notallow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.

Id. at 382, 438 N.Y.S.2d at 275, 420 N.E.2d at 73.

Many of the later cases build on the principles established in Quinlan, Saikewicz and Storar/Eichner. For instance, in In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), the same court that decided Quinlan considered whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing-home resident suffering irreversible mental and physical ailments. While recognizing that a federal right of privacy might apply in the case, the court, contrary to its approach in Quinlan, decided to base its decision on the common law right to self-determination and informed consent. 98 N.J. at 348, 486 A.2d at 1223.

On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice.

Id. at 353-354, 486 A.2d at 1225.

Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decisionmaker using a "subjective" standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective "best interest" standards. Id. at 361-368, 486 A.2d at 1229-1233. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish a person's wishes for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its satisfactions, treatment could be terminated under a "limited-objective" standard. Where no trustworthy evidence existed, and a person's suffering would make the administration of life-sustaining treatment inhumane, a "pure-objective" standard could be used to terminate treatment. If none of these conditions obtained, the court held it was best to err in favor of preserving life. Id. at 364-368, 486 A.2d at 1231-1233.

The court also rejected certain categorical distinctions that had been drawn in prior refusal-of-treatment cases as lacking substance for decision purposes: the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease; between treating individuals as an initial matter versus withdrawing treatment afterwards; between ordinary versus extraordinary treatment; and between treatment by artificial feeding versus other forms of life sustaining medical procedures. Id.. at 369-374, 486 A.2d at 1233-1237. As to the last item, the court acknowledged the "emotional significance" of food, but noted that feeding by implanted tubes is a medical procedur[e] with inherent risks and possible side effects, instituted by skilled healthcare providers to compensate for impaired physical functioning which analytically was equivalent to artificial breathing using a respirator. Id. at 373, 486 A.2d at 1236.[n4]

In contrast to Conroy, the Court of Appeals of New York recently refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of her right to refuse treatment by a surrogate decisionmaker. In re Westchester County Medical Center on behalf of O'Connor, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988) (O'Connor). There, the court, over the objection of the patient's family members, granted an order to insert a feeding tube into a 77-year-old woman rendered incompetent as a result of several strokes. While continuing to recognize a common law right to refuse treatment, the court rejected the substituted judgment approach for asserting it because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

Id. at 530, 534 N.Y.S.2d at 892, 531 N.E.2d at 613 (citation omitted). The court held that the record lacked the requisite clear and convincing evidence of the patient's expressed intent to withhold life-sustaining treatment. Id. at 531-534, 534 N.Y.S.2d at 892-894, 531 N.E.2d at 613-615.

Other courts have found state statutory law relevant to the resolution of these issues. In Conservatorship of Drabick, 200 Cal.App.3d 185, 245 Cal.Rptr. 840, cert. denied, 488 U.S. 958 (1988), the California Court of Appeal authorized the removal of a nasogastric feeding tube from a 44-year-old man who was in a persistent vegetative state as a result of an auto accident. Noting that the right to refuse treatment was grounded in both the common law and a constitutional right of privacy, the court held that a state probate statute authorized the patient's conservator to order the withdrawal of life sustaining treatment when such a decision was made in good faith based on medical advice and the conservatee's best interests. While acknowledging that "to claim that [a patient's] 'right to choose' survives incompetence is a legal fiction at best," the court reasoned that the respect society accords to persons as individuals is not lost upon incompetence, and is best preserved by allowing others "to make a decision that reflects [a patient's] interests more closely than would a purely technological decision to do whatever is possible."[n5] [p276] Id., 200 Cal. App.3d, at 208, 246 Cal.Rptr., at 854-855. See also In re Conservatorship of Torres, 357 N.W.2d 332 (Minn.1984) (Minnesota court had constitutional and statutory authority to authorize a conservator to order the removal of an incompetent individual's respirator since in patient's best interests).

In In re Estate of Longeway, 133 Ill.2d 33, 139 Ill. Dec. 780, 549 N.E.2d 292 (1989), the Supreme Court of Illinois considered whether a 76-year-old woman rendered incompetent from a series of strokes had a right to the discontinuance of artificial nutrition and hydration. Noting that the boundaries of a federal right of privacy were uncertain, the court found a right to refuse treatment in the doctrine of informed consent. Id. at 43-45, 139 Ill.Dec. at 784-785, 549 N.E.2d at 296-297. The court further held that the State Probate Act impliedly authorized a guardian to exercise a ward's right to refuse artificial sustenance in the event that the ward was terminally ill and irreversibly comatose. Id. at 45-47, 139 Ill. Dec. at 786, 549 N.E.2d at 298. Declining to adopt a best interests standard for deciding when it would be appropriate to exercise a ward's right because it "lets another make a determination of a patient's quality of life," the court opted instead for a substituted judgment standard. Id. at 49, 139 Ill.Dec. at 787, 549 N.E.2d at 299. Finding the "expressed intent" standard utilized in O'Connor, supra, too rigid, the court noted that other clear and convincing evidence of the patient's intent could be considered. 133 Ill.2d at 50-51, 139 Ill.Dec. at 787, 549 N.E.2d at 300. The court also adopted the "consensus opinion [that]

treats artificial nutrition and hydration as medical treatment." Id. at 42, 139 Ill.Dec. at 784, 549 N.E.2d at 296. Cf. McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 705, [p277] 553 A.2d 596, 603 (1989) (right to withdraw artificial nutrition and hydration found in the Connecticut Removal of Life Support Systems Act, which "provid[es] functional guidelines for the exercise of the common law and constitutional rights of self-determination"; attending physician authorized to remove treatment after finding that patient is in a terminal condition, obtaining consent of family, and considering expressed wishes of patient).[n6]

As these cases demonstrate, the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these decisions demonstrate both similarity and diversity in their approach to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources -- state constitutions, statutes, and common law -- which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in Twin City Bank v. Nebeker, 167 U.S. 196, 202 (1897), where we said that, in deciding a question [p278] of such magnitude and importance ... it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.

The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. In Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905), for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease. Decisions prior to the incorporation of the Fourth Amendment into the Fourteenth Amendment analyzed searches and seizures involving the body under the Due Process Clause and were thought to implicate substantial liberty interests. See, e.g., Breithaupt v. Abram, 352 U.S. 432, 439 (1957) ("As against the right of an individual that his person be held inviolable ... must be set the interests of society....")

Just this Term, in the course of holding that a State's procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, we recognized that prisoners possess a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.

Washington v. Harper, 494 U.S. 210, 221-222 (1990); see also id. at 229 ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). Still other cases support the recognition of a general liberty interest in refusing medical treatment. Vitek v. Jones, 445 U.S. 480, 494 (1980) (transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); Parham v. J.R., 442 U.S. 584, 600 (1979) ("a child, in common with adults, has a substantial liberty [p279] interest in not being confined unnecessarily for medical treatment").

But determining that a person has a "liberty interest" under the Due Process Clause does not end the inquiry;[n7] "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests."

Youngberg v. Romeo, 457 U.S. 307, 321 (1982). See also Mills v. Rogers, 457 U.S. 291, 299 (1982).

Petitioners insist that, under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person. They rely primarily on our decisions in Parham v. J.R., supra, and Youngberg v. Romeo, 457 U.S. 307 (1982). In Parham, we held that a mentally disturbed minor child had a liberty interest in "not being confined unnecessarily for medical treatment," 442 U.S. at 600, but we certainly did not intimate that such a minor child, after commitment, would have a liberty interest in refusing treatment. In Youngberg, we held that a seriously retarded adult had a liberty [p280] interest in safety and freedom from bodily restraint, 457 U.S. at 320. Youngberg, however, did not deal with decisions to administer or withhold medical treatment.

The difficulty with petitioners' claim is that, in a sense, it begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that, under certain circumstances, a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not.

Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States -- indeed, all civilized nations -- demonstrate their commitment to life by treating homicide as serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.[n8] We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death. [p281]

But in the context presented here, a State has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, "[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient." In re Jobes, 108 N.J. 394, 419, 529 A.2d 434, 477 (1987). A State is entitled to guard against potential abuses in such situations. Similarly, a State is

entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it.[n9] See Ohio v. Akron Center for Reproductive [497 U.S. 282] Health, post at 515-516 (1990). Finally, we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

In our view, Missouri has permissibly sought to advance these interests through the adoption of a "clear and convincing" standard of proof to govern such proceedings.

The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is toinstruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.

Addington v. Texas, 441 U.S. 418, 423 (1979) (quoting In re Winship, 397 U.S. 358, 370 (1970) (Harlan, J., concurring)).

This Court has mandated an intermediate standard of proof -- "clear and convincing evidence" -- when the individual interests at stake in a state proceeding are both "particularly important" and "more substantial than mere loss of money."

Santosky v. Kramer, 455 U.S. 745, 756 (1982) (quoting Addington, supra, at 424). Thus, such a standard has been required in deportation proceedings, Woodby v. INS, 385 U.S. 276 (1966), in denaturalization proceedings, Schneiderman v. United States, 320 U.S. 118 (1943), in civil commitment proceedings, Addington, supra, and in proceedings for the termination of parental rights. Santosky, supra.[n10] Further, [p283] this level of proof, or an even higher one, has traditionally been imposed in cases involving allegations of civil fraud, and in a variety of other kinds of civil cases involving such issues as ... lost wills, oral contracts to make bequests, and the like.

Woodby, supra, 385 U.S. at 285, n. 18.

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as "a societal judgment about how the risk of error should be distributed between the litigants." Santosky, supra, 455 U.S. at 755; Addington, supra, 441 U.S. at 423. The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life sustaining treatment, however, is not susceptible of correction. In Santosky, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was final and irrevocable. Santosky, supra, 455 U.S. at 759. The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan, which all agree will result in her death. [p284]

It is also worth noting that most, if not all, States simply forbid oral testimony entirely in determining the wishes of parties in transactions which, while important, simply do not

have the consequences that a decision to terminate a person's life does. At common law and by statute in most States, the parol evidence rule prevents the variations of the terms of a written contract by oral testimony. The statute of frauds makes unenforceable oral contracts to leave property by will, and statutes regulating the making of wills universally require that those instruments be in writing. See 2 A. Corbin, Contracts § 398, pp. 360-361 (1950); 2 W. Page, Law of Wills §§ 19.3-19.5, pp. 61-71 (1960). There is no doubt that statutes requiring wills to be in writing, and statutes of frauds which require that a contract to make a will be in writing, on occasion frustrate the effectuation of the intent of a particular decedent, just as Missouri's requirement of proof in this case may have frustrated the effectuation of the not-fully-expressed desires of Nancy Cruzan. But the Constitution does not require general rules to work faultlessly; no general rule can.

In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof for such evidence. See, e.g., Longeway, 133 Ill.2d at 50-51, 139 Ill.Dec. at 787, 549 N.E.2d at 300; McConnell, 209 Conn., at 707-710, 553 A.2d at 604-605; O'Connor, 72 N.Y.2d at 529-530, 531 N.E.2d at 613; In re Gardner, 534 A.2d 947, 952-953 (Me.1987); In re Jobes, 108 N.J. at 412-413, 529 A.2d [p285] at 443; Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 11, 426 N.E.2d 809, 815 (1980).

The Supreme Court of Missouri held that, in this case, the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. In so doing, it reversed a decision of the Missouri trial court, which had found that the evidence "suggest[ed]" Nancy Cruzan would not have desired to continue such measures, App. to Pet. for Cert. A98, but which had not adopted the standard of "clear and convincing evidence" enunciated by the Supreme Court. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements, made to a housemate about a year before her accident, that she would not want to live should she face life as a "vegetable," and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.[n11]

Petitioners alternatively contend that Missouri must accept the "substituted judgment" of close family members even in the absence of substantial proof that their views reflect [p286] the views of the patient. They rely primarily upon our decisions in Michael H. v. Gerald D., 491 U.S. 110 (1989), and Parham v. J.R., 442 U.S. 584 (1979). But we do not think these cases support their claim. In Michael H., we upheld the constitutionality of California's favored treatment of traditional family relationships; such a holding may not be turned around into a constitutional requirement that a State must recognize the primacy of those relationships in a situation like this. And in Parham, where the patient was a minor, we also upheld the constitutionality of a state scheme in which parents made certain decisions for mentally ill minors. Here again, petitioners would seek to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking. But constitutional law does not work that way.

No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of "substituted judgment" with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling -- a feeling not at all ignoble or unworthy, but not entirely disinterested, either -- that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may [p287] choose to defer only to those wishes, rather than confide the decision to close family members.[n12]

The judgment of the Supreme Court of Missouri is
Affirmed.

1. This US Supreme Court case focuses on the right to die and not assisted suicide. What are three ways this case could be used to set precedent for an assisted suicide case? Are there any reasons this case wouldn't set precedent for an assisted suicide case?

2. Based on what you've read about the standards applied in situations where assisted suicide is legal, do you think that those standards were met in Cruzan's case? Based on that, do you think the Cruzan family should have been permitted to cease the life-sustaining measures keeping their daughter alive?

EXCERPT FROM *BOUVIA V. SUPERIOR COURT*, BY JUDGE J. BEACH, FROM THE COURT OF APPEALS OF CALIFORNIA, SECOND DISTRICT, DIVISION TWO, APRIL 16, 1986

Petitioner, Elizabeth Bouvia, a patient in a public hospital, seeks the removal from her body of a nasogastric tube inserted and maintained against her will and without her consent by physicians who so placed it for the purpose of keeping her alive through involuntary forced feeding.

Petitioner has here filed a petition for writ of mandamus and other extraordinary relief after the trial court denied her a preliminary injunction requiring that the tube be removed and that the hospital and doctors be prohibited from using any other similar procedures. We issued an alternative writ. We have heard oral argument from the parties and now order issuance of a peremptory writ, granting petitioner, Elizabeth Bouvia, the relief for which she prayed.

DISCUSSION

1. AVAILABILITY OF IMMEDIATE RELIEF HERE.

It is appropriate for this court to immediately determine the issues raised by this petition. We realize that by deciding the pivotal issue presented our ruling will affect the entire lawsuit, including causes of action on which there has yet been no plenary trial. But this is an unusual case. Although important to real parties in interest, it is urgent to petitioner.

The trial court denied petitioner's request for the immediate relief she sought. It concluded that leaving the tube in place was necessary to prolong petitioner's life, and that it would, in fact, do so. With the tube in place petitioner probably will survive the time required to prepare for trial, a trial itself and an appeal, if one proved necessary. The real party-physicians also assert, and the trial court agreed, that physically petitioner tolerates the tube reasonably well and thus is not in great physical discomfort.

Real parties' counsel therefore argue that the normal course of trial and appeal provide a sufficient remedy. But petitioner's ability to tolerate physical discomfort does not diminish her right to immediate relief. Her mental and emotional feelings are equally entitled to respect. She has been subjected to the forced intrusion of an artificial mechanism into her body against her will. She has a right to refuse the increased dehumanizing aspects of her condition created by the insertion of a permanent tube through her nose and into her stomach.

To petitioner it is a dismal prospect to live with this hated and unwanted device attached to her, through perhaps years of the law's slow process. [1135] She has the right to have it removed immediately. This matter constitutes a perfect paradigm of the axiom: "Justice delayed is justice denied."

By refusing petitioner the relief which she sought, the trial court, with the most noble intentions, attempted to exercise its discretion by issuing a ruling which would uphold what it considered a lawful object, i.e., keeping Elizabeth Bouvia alive by a means which it considered ethical. Nonetheless, it erred for it had no discretion to exercise. Petitioner sought to enforce only a right which was exclusively hers and over which neither the medical profession nor the judiciary have any veto power. The trial court could but recognize and protect her exercise of that right.

In explanation of its ruling, the trial court stated that it considered petitioner's "motives" to be indicative of an attempt to commit suicide with the state's help rather than a bona fide exercise of her right to refuse medical treatment. No evidence supports this conclusion.

As previously noted, the legal remedies available to petitioner through the normal course of trial and appeal are wholly inadequate. Therefore, a prompt resolution, even though based upon a provisional ruling, is justified, particularly when it will probably completely resolve this tragic case.[1]

Counsel for both sides have filed excellent and thorough briefs. We also have before us a voluminous record of everything submitted to the trial court. It includes the case's history, transcripts of prior proceedings, depositions, the points and authorities submitted to the trial court and copies of statutes, policy statements, and decisions of other jurisdictions throughout the country. A further trial would establish nothing factually new. The basic and essential facts are not in serious dispute. In the few areas of disagreement we accept, as we must, the findings of the trial judge who, after a careful hearing, made a thorough and well prepared record and statement of decision. In sum, we believe we are presently able to decide the only issue now before us.

2. FACTUAL BACKGROUND

Petitioner is a 28-year-old woman. Since birth she has been afflicted with and suffered from severe cerebral palsy. She is quadriplegic. She is now a patient at a public hospital maintained by one of the real parties in interest, the County of Los Angeles. Other parties are physicians, nurses and the [1136] medical and support staff employed by the County of Los Angeles. Petitioner's physical handicaps of palsy and quadriplegia have progressed to the point where she is completely bedridden. Except for a few fingers of one hand and some slight head and facial movements, she is immobile. She is physically helpless and wholly unable to care for herself. She is totally dependent upon others for all of her needs. These include feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions. She cannot stand or sit upright in bed or in a wheelchair. She lies flat in bed and must do so the rest of her life. She suffers also from degenerative and severely crippling arthritis. She is in continual pain. Another tube permanently attached to her chest automatically injects her with periodic doses of morphine which relieves some, but not all of her physical pain and discomfort.

She is intelligent, very mentally competent. She earned a college degree. She was married but her husband has left her. She suffered a miscarriage. She lived with her parents until her father told her that they could no longer care for her. She has stayed intermittently with friends and at public facilities. A search for a permanent place to live where she might receive the constant care which she needs has been unsuccessful. She is without financial means to support herself and, therefore, must accept public assistance for medical and other care.

She has on several occasions expressed the desire to die. In 1983 she sought the right to be cared for in a public hospital in Riverside County while she intentionally "starved herself to death." A court in that county denied her judicial assistance to accomplish that goal. She later abandoned an appeal from that ruling. Thereafter, friends took her to several different facilities, both public and private, arriving finally at her present location. Efforts by the staff of real party in interest County of Los Angeles and its social workers to find her an apartment of her own with publicly paid live-in help or regular visiting nurses to care for her, or some other suitable facility, have proved fruitless.

Petitioner must be spoon fed in order to eat. Her present medical and dietary staff have determined that she is not consuming a sufficient amount of nutrients. Petitioner stops eating when she feels she cannot orally swallow more, without nausea and vomiting. As she cannot now retain solids, she is fed soft liquid-like food. Because of her previously announced resolve to starve herself, the medical staff feared her weight loss might reach a life-threatening level. Her weight since admission to real parties' facility seems to hover between 65 and 70 pounds. Accordingly, they inserted the subject tube against her will and contrary to her express written instructions.[2]

[1137] Petitioner's counsel argue that her weight loss was not such as to be life threatening and therefore the tube is unnecessary. However, the trial court found to the contrary as a matter of fact, a finding which we must accept. Nonetheless, the point is immaterial, for, as we will explain, a patient has the right to refuse any medical treatment or medical service, even when such treatment is labelled "furnishing nourishment and hydration." This right exists even if its exercise creates a "life threatening condition."

3. THE RIGHT TO REFUSE MEDICAL TREATMENT.

(1) "[A] person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment." *(Cobbs v. Grant* (1972) 8 Cal.3d 229, 242 [104 Cal. Rptr. 505, 502 P.2d 1].) It follows that

such a patient has the right to refuse any medical treatment, even that which may save or prolong her life. *(Barber v. Superior Court* (1983) 147 Cal. App.3d 1006 [195 Cal. Rptr. 484]; *Bartling v. Superior Court* (1984) 163 Cal. App.3d 186 [209 Cal. Rptr. 220].) In our view the foregoing authorities are dispositive of the case at bench. Nonetheless, the county and its medical staff contend that for reasons unique to this case Elizabeth Bouvia may not exercise the right available to others. Accordingly, we again briefly discuss the rule in the light of real parties' contentions.

The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. (Cal. Const., art. I, § 1; *Griswold v. Connecticut* (1965) 381 U.S. 479, 484 [14 L.Ed.2d 510, 514-515, 85 S.Ct. 1678]; *Bartling* v *Superior Court, supra*, 163 Cal. App.3d 186.) Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.

In Barber v. Superior Court, supra, 147 Cal. App.3d 1006, we considered this same issue although in a different context. Writing on behalf of this division, Justice Compton thoroughly analyzed and reviewed the issue of withdrawal of life-support systems beginning with the seminal case of the Matter of Quinlan (1976) 70 N.J. 10 [355 A.2d 647], cert. den. 429 U.S. 922 [50 L.Ed.2d 289, 97 S.Ct. 319], and continuing on to the then recent enactment of the California Natural Death Act (Health & Saf. Code, §§ 7185-7195). (2) His opinion clearly and repeatedly stresses the fundamental underpinning of its conclusion, i.e., the patient's right to decide: at page 1015, "In this state a clearly recognized legal right to control one's own medical treatment predated the Natural Death Act. A long line of cases, approved by the Supreme Court in *Cobbs v. Grant* (1972) 8 Cal.3d 229 ... have held that where a doctor performs treatment in the absence of an [1138] informed consent, there is an actionable battery. The obvious corollary to this principle is that *a competent adult patient has the legalrightto refuse medical treatment"* (italics added); at page 1019, "*[T]he patient's interests and desires are the key ingredients* of the decision-making process" (italics added); at page 1020, "Given the general standards for determining when there is a duty to provide medical treatment of debatable value, the question still remains as to who should make these vital decisions. Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, whenever possible, *the patient himself should then be the ultimate decisionmaker"* (italics added); at page 1021, "The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of *the patient's own desires* and feelings, to the extent that they were expressed before the patient became incompetent." (Italics added.)

Bartling v. Superior Court, supra, 163 Cal. App.3d 186, was factually much like the case at bench. Although not totally identical in all respects, the issue there centered on the same question here present: i.e., "May the patient refuse even life continuing treatment?" Justice Hastings, writing for another division of this court, explained: "In this case we are called upon to decide whether a competent adult patient, with serious illnesses which are probably incurable but have not been diagnosed as terminal, has the right, over the objection of his physicians and the hospital, to have life-support equipment disconnected despite the fact that withdrawal of such devices will surely hasten his death." (At p. 189.) "(1) Mr. Bartling's illnesses were serious but not terminal, and had not been diagnosed as such; (2) although Mr. Bartling was attached to a respirator to facilitate breathing, he was not in a vegetative state and was not comatose; and (3) Mr. Bartling was competent in the legal sense. [¶] ... The court below concluded that as long as there was some potential for

restoring Mr. Bartling to a 'cognitive, sapient life,' it would not be appropriate to issue an injunction in this case. [¶] (3) We conclude that the trial court was incorrect when it held that the right to have life-support equipment disconnected was limited to comatose, terminally ill patients, or representatives acting on their behalf." (At p. 193.)

The description of Mr. Bartling's condition fits that of Elizabeth Bouvia. The holding of that case applies here and compels real parties to respect her decision even though she is not "terminally" ill. The trilogy of *Cobbs v. Grant, supra*, 8 Cal.3d 229, *Barber v. Superior Court, supra*, 147 Cal. App.3d 1006, and *Bartling v. Superior Court, supra*, 163 Cal. App.3d 186, with their thorough explanation and discussion, are authority enough [1139] and in reality provide a complete answer to the position and assertions of real parties' medical personnel.

But if additional persuasion be needed, there is ample. As indicated by the discussion in Bartling and Barber, substantial and respectable authority throughout the country recognize the right which petitioner seeks to exercise. Indeed, it is neither radical nor startlingly new. It is a basic and constitutionally predicated right. More than 70 years ago, Judge Benjamin Cardozo observed: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body...." *(Schloendorff v. Society of New York Hospital* (1914) 211 N.Y. 125 [105 N.E. 92, 93].)

Matter of Spring (1980) 380 Mass. 629 [405 N.E.2d 115]; *Lane v. Candura* (Mass. App. 1978) 6 Mass. App. 377 [376 N.E.2d 1232]; *Matter of Quackenbush* (1978) 156 N.J. Super. 282 [383 A.2d 785]; *Matter of Conroy* (1985) 98 N.J. 321 [486 A.2d 1209]; *Satz v. Perlmutter* (Fla. 1980) 379 So.2d 359, affg. 362 So.2d 160 (Fla.App. 1978); *In re Osborne* (D.C.App. 1972) 294 A.2d 372; and *Superintendent of Belchertown v. Saikewicz* (1977) 373 Mass. 728 [370 N.E.2d 417], are but a few examples of the decisions that have upheld a patient's right to refuse medical treatment even at risk to his health or his very life.

(4) Further recognition that this right is paramount to even medical recommendation is evidenced by several declarations of public and professional policy which were noted in both the Barber and Bartling cases.

For example, addressing one part of the problem, California passed the "Natural Death Act," Health and Safety Code section 7185 et seq. Although addressed to terminally ill patients, the significance of this legislation is its expression as state policy "that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care...." (Health & Saf. Code, § 7186.) Section 7188 provides the method whereby an adult person may execute a directive for the withholding or withdrawal of life-sustaining procedures. Recognition of the right of other persons who may not be terminally ill and may wish to give other forms of direction concerning their medical care is expressed in section 7193: "Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative."

(5) Moreover, as the Bartling decision holds, there is no practical or logical reason to limit the exercise of this right to "terminal" patients. The [1140] right to refuse treatment does not need the sanction or approval by any legislative act, directing how and when it shall be exercised.

(6) In large measure the courts have sought to protect and insulate medical providers from criminal and tort liability. (E.g., *Barber v. Superior Court, supra*, 147 Cal. App.3d 1106.) The California Natural Death Act also illustrates this approach. Nonetheless, as indicated, it too recognizes, even if inferentially, the existence of the right, even in a nonterminal patient, which overrides the concern for protecting the medical profession.

(7) This right is again reflected in the statute concerning execution of a power of attorney for health care (Civ. Code, § 2500), which states in pertinent part: "NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME…."

Title 22 of the California Administrative Code provides guidelines for health facilities. Section 70707 directs that hospitals and medical staffs shall adopt and post a written policy on patients' rights which shall include the right to "(5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment … (6) Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment."

(8) A recent Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded in part: "The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken, just as such choices provide the basis for other decisions about medical treatment. Health care institutions and professionals should try to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options…. Health care professionals serve patients best by maintaining a presumption in favor of sustaining life, while recognizing that competent patients are entitled to choose to forego any treatments, including those that sustain life." *(Deciding to Forego Life-Sustaining Treatment*, at pp. 3, 5 (U.S. GPO 1983) (Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research).)

On December 11, 1985, the Los Angeles County Bar Association, and on January 6, 1986, the Los Angeles County Medical Association recognized as general principles for decision making the conclusions as expressly stated [1141] in the cases of Barber and Bartling and endorsed the conclusion of the Presidential Commission cited above. (Principles and Guidelines Concerning the Foregoing of Life-Sustaining Treatment for Adult Patients.)

The American Hospital Association (AHA) Policy and Statement of Patients' Choices of Treatment Options, approved by the American Hospital Association in February of 1985 discusses the value of a collaborative relationship between the patient and the physician and states in pertinent part: "Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patient" and "the right to choose treatment includes the right to refuse a specific treatment or all treatment. …"

Again, this statement reflects the fact that the controlling decision belongs to a competent, informed patient. It also contains a discussion of how that consent should be documented, and the desirability of a cooperative effort. Of course, none of the problems of incapacity due to age, unconsciousness, mental disease or disability mentioned in the policy statement affect the case before us.

Significant also is the statement adopted on March 15, 1986, by the Council on Ethical and Judicial Affairs of the American Medical Association. It is entitled "Withholding or Withdrawing Life Prolonging Medical Treatment." (9) In pertinent part, it declares: "The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. [¶] Life prolonging medical treatment includes medication and artificially or technologically

supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained."

We do not believe that all of the foregoing case law and statements of policy and statutory recognition are mere lip service to a fictitious right. As noted in Bartling "We do not doubt the sincerity of [the hospital and medical personnel's] moral and ethical beliefs, or their sincere belief in the position they have taken in this case. (10) However, if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors.... The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged." (Fn. omitted; 163 Cal. App.3d at p. 195.)

[1142] It is indisputable that petitioner is mentally competent. She is not comatose. She is quite intelligent, alert, and understands the risks involved.

4. THE CLAIMED EXCEPTIONS TO THE PATIENT'S RIGHT TO CHOOSE ARE INAPPLICABLE.

As in *Bartling* the real parties in interest, a county hospital, its physicians and administrators, urge that the interests of the state should prevail over the rights of Elizabeth Bouvia to refuse treatment. Advanced by real parties under this argument are the state's interests in (1) preserving life, (2) preventing suicide, (3) protecting innocent third parties, and (4) maintaining the ethical standards of the medical profession, including the right of physicians to effectively render necessary and appropriate medical service and to refuse treatment to an uncooperative and disruptive patient. Included, whether as part of the above or as separate and additional arguments, are what real parties assert as distinctive facts not present in other cases, i.e., (1) petitioner is a patient in a public facility, thereby making the state a party to the result of her conduct, (2) she is not comatose, nor incurably, nor terminally ill, nor in a vegetative state, all conditions which have justified the termination of life-support system in other instances, (3) she has asked for medical treatment, therefore, she cannot accept a part of it while cutting off the part that would be effective, and (4) she is, in truth, trying to starve herself to death and the state will not be a party to a suicide.

Nearly all of these arguments are answered by the discussion and reasoning in the *Bartling* and *Barber* cases. Nonetheless, we address ourselves briefly to some of the asserted factual differences between Mr. Bartling or patients in the other cited cases and Mrs. Bouvia. We conclude they are insufficient to deny her the right to refuse medical treatment afforded others.

(11) At bench the trial court concluded that with sufficient feeding petitioner could live an additional 15 to 20 years; therefore, the preservation of petitioner's life for that period outweighed her right to decide. In so holding the trial court mistakenly attached undue importance to the amount of time possibly available to petitioner, and failed to give equal weight and consideration for the quality of that life; an equal, if not more significant, consideration.

All decisions permitting cessation of medical treatment or life-support procedures to some degree hastened the arrival of death. In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished. In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly [1143] in bed, unable to care for herself, may consider her existence

meaningless. She cannot be faulted for so concluding. If her right to choose may not be exercised because there remains to her, in the opinion of a court, a physician or some committee, a certain arbitrary number of years, months, or days, her right will have lost its value and meaning.

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.

(12) Here Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's alone.

(13) Adapting the language of *Satz v. Perlmutter, supra*, 362 So.2d 160, "It is all very convenient to insist on continuing [Elizabeth Bouvia's] life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against [her] competent will, thus inflicting never ending physical torture on [her] body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes [her] freedom of choice and invades [her] right to self-determine." *(Satz v. Perlmutter, supra*, at p. 164.)

Here, if force fed, petitioner faces 15 to 20 years of a painful existence, endurable only by the constant administrations of morphine. Her condition is irreversible. There is no cure for her palsy or arthritis. Petitioner would have to be fed, cleaned, turned, bedded, toileted by others for 15 to 20 years! Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness. We do not believe it is the policy of this state that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure, for "15 to 20 [1144] years." We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.

(14) It is, therefore, immaterial that the removal of the nasogastric tube will hasten or cause Bouvia's eventual death. Being competent she has the right to live out the remainder of her natural life in dignity and peace. It is precisely the aim and purpose of the many decisions upholding the withdrawal of life-support systems to accord and provide as large a measure of dignity, respect and comfort as possible to every patient for the remainder of his days, whatever be their number. This goal is not to hasten death, though its earlier arrival may be an expected and understood likelihood.

Real parties assert that what petitioner really wants is to "commit suicide" by starvation at their facility. The trial court in its statement of decision said: "It is fairly clear from the evidence and the court cannot close its eyes to the fact that [petitioner] during her stay in defendant hospital, and for some time prior thereto, has formed an intent to die. She has voiced this desire to a member of the staff of defendant hospital. She claims, however, she does not wish to commit suicide. On the evidence, this is but a semantic distinction. The reasonable inference to be drawn from the evidence is that [petitioner] in defendant facility has purposefully engaged in a selective rejection of medical treatment and nutritional

intake to accomplish her objective and accept only treatment which gives her some degree of comfort pending her demise. Stated another way, [petitioner's] refusal of medical treatment and nutritional intake is motivated not by a bona fide exercise of her right of privacy but by a desire to terminate her life.... [¶] Here [petitioner] wishes to pursue her objective to die by the use of public facilities with staff standing by to furnish her medical treatment to which she consents and to refrain from that which she refuses."

(15) Overlooking the fact that a desire to terminate one's life is probably the ultimate exercise of one's right to privacy, we find no substantial evidence to support the court's conclusion. Even if petitioner had the specific intent to commit suicide in 1983, while at Riverside, she did not carry out that plan. Then she apparently had the ability, without artificial aids, to consume sufficient nutrients to sustain herself; now she does not. That is to say, the trial court here made the following express finding, "Plaintiff, when she chooses, can orally ingest food by masticating 'finger food' *though additional nutritional intake is required intravenously and by nasogastric tube*. ..." (Italics added.) As a consequence of her changed condition, it is clear she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting [1145] therein. *(Bartling v. Superior Court, supra*, 163 Cal. App.3d 186; *Lane v. Candura, supra*, 376 N.E.2d 1232.)

Moreover, the trial court seriously erred by basing its decision on the "motives" behind Elizabeth Bouvia's decision to exercise her rights. If a right exists, it matters not what "motivates" its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's motives meet someone else's approval. It certainly is not illegal or immoral to prefer a natural, albeit sooner, death than a drugged life attached to a mechanical device.

(16) It is not necessary to here define or dwell at length upon what constitutes suicide. Our Supreme Court dealt with the matter in the case of *In re Joseph G*. (1983) 34 Cal.3d 429 [194 Cal. Rptr. 163, 667 P.2d 1176, 40 A.L.R.4th 690], wherein, declaring that the state has an interest in preserving and recognizing the sanctity of life, it observed that it is a crime to aid in suicide. But it is significant that the instances and the means there discussed all involved affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison, knife, or other instrumentality or usable means by which another could physically and immediately inflict some death-producing injury upon himself. Such situations are far different than the mere presence of a doctor during the exercise of his patient's constitutional rights.

This is the teaching of *Bartling* and *Barber*. No criminal or civil liability attaches to honoring a competent, informed patient's refusal of medical service.

(17) We do not purport to establish what will constitute proper medical practice in all other cases or even other aspects of the care to be provided petitioner. We hold only that her right to refuse medical treatment, even of the life-sustaining variety, entitles her to the immediate removal of the nasogastric tube that has been involuntarily inserted into her body. The hospital and medical staff are still free to perform a substantial if not the greater part of their duty, i.e., that of trying to alleviate Bouvia's pain and suffering.

Petitioner is without means to go to a private hospital and, apparently, real parties' hospital as a public facility was required to accept her. Having done so it may not deny her relief from pain and suffering merely because she has chosen to exercise her fundamental right to protect what little privacy remains to her.

(18) Personal dignity is a part of one's right of privacy. Such a right of bodily privacy led the United States Supreme Court to hold that it shocked its conscience to learn that a state,

even temporarily, had put a tube into the [1146] stomach of a criminal defendant to recover swallowed narcotics. *(Rochin v. California* (1952) 342 U.S. 165 [96 L.Ed. 183, 72 S.Ct. 205].) Petitioner asks for no greater consideration.

IT IS ORDERED:

Let a peremptory writ of mandate issue commanding the Los Angeles Superior Court immediately upon receipt thereof, to make and enter a new and different order granting Elizabeth Bouvia's request for a preliminary injunction, and the relief prayed for therein; in particular to make an order (1) directing real parties in interest forthwith to remove the nasogastric tube from petitioner, Elizabeth Bouvia's body, and (2) prohibiting any and all of the real parties in interest from replacing or aiding in replacing said tube or any other or similar device in or on petitioner without her consent. Pursuant to Rule 24(c), California Rules of Court, this Order is final as to this court upon filing.

Roth, P.J., and Compton, J., concurred.

COMPTON, J.

Although I have concurred in the very well reasoned and superbly crafted opinion of my colleague Justice Beach, I feel compelled to write separately and reflect on what I consider to be one of the real tragedies of this case, which is that Elizabeth Bouvia has had to go to such ends to obtain relief from her suffering.

Fate has dealt this young woman a terrible hand. Can anyone blame her if she wants to fold her cards and say "I am out"? Yet medical personnel who have had charge of her case have attempted to force Elizabeth to continue in the game. In their efforts they have been abetted by two different trial courts.

This is not to say that those members of the medical profession and those courts were not well motivated. In each instance the persons involved have expressed a concern for the sanctity of life and a desire to avoid any conduct that could be characterized as aiding in a suicide. Undoubtedly, those persons were, in no small way, influenced by the presence in our law of Penal Code section 401, which imposes penal sanctions on persons who aid and abet in a suicide.

In my opinion, as I shall point out, the application of that statute to circumstances such as are present here is archaic and inhumane.

I have no doubt that Elizabeth Bouvia wants to die; and if she had the full use of even one hand, could probably find a way to end her life — in a [1147] word — commit suicide. In order to seek the assistance which she needs in ending her life by the only means she sees available — starvation — she has had to stultify her position before this court by disavowing her desire to end her life in such a fashion and proclaiming that she will eat all that she can physically tolerate. Even the majority opinion here must necessarily "dance" around the issue.

Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision. This state and the medical profession, instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to

enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

That ability should not be hampered by the state's threat to impose penal sanctions on those who might be disposed to lend assistance.

The medical profession, freed of the threat of governmental or legal reprisal, would, I am sure, have no difficulty in accommodating an individual in Elizabeth's situation.

The Hippocratic Oath reads in pertinent part: "... I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients.... I will give no deadly medicine to anyone if asked...." Surely, adherence to that oath would yet admit of a reasonable balancing between the doctor's obligation to alleviate suffering and his obligation to preserve life, remembering that the term "life" has itself recently undergone substantial redefinition.

It is also worth noting that the original oath also contained the phrase "... I will not give to a woman an instrument to produce abortion...." Obviously, the profession has already accommodated a deviation from that part of the oath.

Whatever choice Elizabeth Bouvia may ultimately make, I can only hope that her courage, persistence and example will cause our society to deal realistically with the plight of those unfortunate individuals to whom death beckons as a welcome respite from suffering.

[1148] If there is ever a time when we ought to be able to get the "government off our backs" it is when we face death — either by choice or otherwise.

The petition of real parties in interest for review by the Supreme Court was denied June 5, 1986.

1. Bouvia's case argued that forcing life-saving measures on the petitioner against her will was equivalent to torture and battery. Based on what you've read of this case and others in the book, do you believe the hospital had the right or obligation to keep Bouvia alive?

2. The Bouvia case was decided more than thirty years ago. Based on the more recent articles you've read about the right to die and assisted suicide, what influence do you think the Bouvia case had on how we think about these instances now?

CHAPTER 4

WHAT ADVOCATES SAY

With assisted suicide being so controversial, it's no surprise that there are advocacy groups on both sides of the debate who believe that their views are the only correct ones. Many of those who support physician-assisted suicide believe that everyone has the right to choose when and how to die, while those who oppose it do so for a variety of reasons, though often those reasons are religious or moral in nature. As you read the arguments put forward by the groups in this chapter, think about not only whether you agree with them, but whether their arguments should be considered when determining the legality of assisted suicide.

"WE HAVE A RIGHT TO DIE WITH DIGNITY. THE MEDICAL PROFESSION HAS A DUTY TO ASSIST," BY ANTON

VAN NIEKERK, FROM *THE CONVERSATION*, OCTOBER 25, 2016

Euthanasia represents one of the oldest issues in medical ethics. It is forbidden in the original Hippocratic Oath, and has consistently been opposed by most religious traditions since antiquity – other than, incidentally, abortion, which has only been formally banned by the Catholic Church since the middle of the 19th century.

Euthanasia is a wide topic with many dimensions. I will limit myself in this article to the issue of assisted death, which seems to me to be one of the most pressing issues of our time.

Desmond Tutu, emeritus archbishop of Cape Town, raised it again on his 85th birthday in an article in the Washington Post. He wrote:

> I have prepared for my death and have made it clear that I do not wish to be kept alive at all costs. I hope I am treated with compassion and allowed to pass onto the next phase of life's journey in the manner of my choice.

Assisted death can take the form of physician assisted suicide (PAS). Here a suffering and terminal patient is assisted by a physician to gain access to a lethal substance which the patient himself or herself takes or administers. If incapable of doing so, the physician – on request of the patient – administers the lethal substance which terminates the patient's life.

The latter procedure is also referred to as "voluntary active euthanasia" (VAE). I will not deal with the issue of involuntary euthanasia –where the suffering patient's life is

terminated without their explicit consent -– a procedure which, to my mind, is ethically much more problematic.

PASSIVE FORM OF EUTHANASIA

The term “voluntary active euthanasia” suggests that there also is a passive form of euthanasia. It is passive in the sense that nothing is “actively” done to kill the patient, but that nothing is done to deter the process of dying either, and that the termination of life-support which is clearly futile, is permitted.

However, the moral significance of the distinction between “active” and “passive” euthanasia is increasingly questioned by ethicists. The reason simply is the credibility of arguing that administering a lethal agent is “active”, but terminating life support (for example switching off a ventilator) is “passive”. Both clearly are observable and describable actions, and both are the direct causes of the patient’s death.

There are a number of reasons for the opposition to physician assisted suicide or voluntary active euthanasia. The value bestowed on human life in all religious traditions and almost all cultures, such as the prohibition on murder is so pervasive that it is an element of common, and not statutory, law.

Objections from the medical profession to being seen or utilised as “killers” rather than saviours of human life, as well as the sometimes well-founded fear of the possible abuse of physician assisted suicide or voluntary active euthanasia, is a further reason. The main victims of such possible abuse could well be the most vulnerable and indigent members of society: the poor, the disabled and the

like. Those who cannot pay for prolonged accommodation in expensive health care facilities and intensive care units.

DEATH WITH DIGNITY

In support of physician assisted suicide or voluntary active euthanasia, the argument is often made that, as people have the right to live with dignity, they also have the right to die with dignity. Some medical conditions are simply so painful and unnecessarily prolonged that the capability of the medical profession to alleviate suffering by means of palliative care is surpassed.

Intractable terminal suffering robs the victims of most of their dignity. In addition, medical science and practice is currently capable of an unprecedented prolongation of human life. It can be a prolongation that too often results in a concomitant prolongation of unnecessary and pointless suffering.

Enormous pressure is placed upon both families and the health care system to spend time and very costly resources on patients that have little or no chance of recovery and are irrevocably destined to die. It is, so the argument goes, not inhumane or irreverent to assist such patients – particularly if they clearly and repeatedly so request – to bring their lives to an end.

I am personally much more in favour of the pro-PAS and pro-VAE positions, although the arguments against do raise issues that need to be addressed. Most of those issues (for example the danger of the exploitation of vulnerable patients) I believe, can be satisfactorily dealt with by regulation.

ARGUMENT IN FAVOUR OF ASSISTED SUICIDE

The most compelling argument in favour of physician assisted suicide or voluntary active euthanasia is the argument in support of committing suicide in a democracy. The right to commit suicide is, as far as I am concerned, simply one of the prices we have to be willing to pay as citizens of a democracy.

We do not have the right, and we play no discernible role, in coming into existence. But we do have the right to decide how long we remain in existence. The fact that we have the right to suicide, does not mean that it is always (morally) right to execute that right.

It is hard to deny the right of an 85-year-old with terminal cancer of the pancreas and almost no family and friends left, to commit suicide or ask for assisted death. In this case, he or she both has the right, and will be in the right if exercising that right.

Compare that with the situation of a 40-year-old man, a husband and father of three young children, who has embezzled company funds and now has to face the music in court. He, also, has the right to commit suicide. But, I would argue, it would not be morally right for him to do so, given the dire consequences for his family. To have a right, does not imply that it is always right to execute that right.

My argument in favour of physician assisted suicide or voluntary active euthanasia is thus grounded in the right to suicide, which I think is fundamental to a democracy.

Take the case of a competent person who is terminally ill, who will die within the next six months and has no prospect of relief or cure. This person suffers intolerably and/or intractably, often because of an irreversible dependence on life-support. This patient repeatedly, say at least twice a week, requests that his/her life be terminated. I am convinced that to perform physician assisted suicide or

voluntary active euthanasia in this situation is not only the humane and respectful, but the morally justified way to go.

The primary task of the medical profession is not to prolong life or to promote health, but to relieve suffering. We have a right to die with dignity, and the medical profession has a duty to assist in that regard.

1. The author argues that physician-assisted suicide is a right we all have, and that the medical community must oblige because it is their duty not to prolong life, but to relieve suffering. Yet he also argues that some people have a moral right to commit suicide, while others do not. Do you believe that both of his arguments can be true? If so, how do you believe the author would craft a right-to-die law?

2. The author differentiates between active assisted suicide—administering a lethal dose of drugs—versus passive—taking someone off life support if that is their wish. What he calls passive assisted suicide is legal in most cases, yet active assisted suicide is not. Why do you think the two are viewed as different? Do you believe the two types of assisted suicide are actually different? Explain using examples from the book.

“OPINION: THE TIME IS NOW FOR THE END-OF-LIFE OPTION ACT IN MARYLAND,” BY KIM CALLINAN, FROM *MARYLANDREPORTER.COM*, FEBRUARY 15, 2017

Thursday afternoon, the House Health and Government Operations Committee will hear testimony on the “Richard E. Israel and Roger ‘Pip’ Moyer End-of-Life Option Act,” HB370.

This legislation offers mentally capable, terminally ill adults with no hope of a cure the option to voluntarily request a prescription for medication from their doctor that they can decide to use to die peacefully if their suffering becomes unbearable.

THE FACTS

Debates about medical aid-in-dying legislation, like the one taking place in Annapolis, are understandably passionate. But it is important that these debates remain based on facts, not on speculation and myth.

The fact is medical aid in dying has been safely practiced for a combined 30-plus years across six states in America: Oregon, Washington, Montana, Vermont, California and Colorado. The law has been carefully studied by doctors and reported on by state agencies and in academic journals.

The conclusions are clear. The laws work as intended. Medical aid in dying is a safe and effective medical practice. In fact, throughout this decades-long history, there has not been a single incidence of abuse or coercion.

The Maryland legislation is based on time-tested safeguards for medical aid-in-dying laws in other states that are necessary to ensure that the terminally ill adult patient is protected, while also recognizing that too many regulatory burdens will make it unnecessarily difficult for dying people to access the law.

TWO DOCTORS, THREE REQUESTS

The legislation requires that two independent doctors certify that the dying person is capable of making their own decisions and is likely to die within six months. Both doctors must also certify that the person has not been coerced.

The law has been carefully crafted to ensure that the dying person is in charge of the process from start to finish:

1) The person must make the request three times — once in writing and twice orally — and they must be alone with the doctor once when they make one request;

2) there is a 15-day waiting period;

3) the person must consult with two different doctors;

4) the person must self-ingest the medication; and

5) at any time during the process, the dying individual can change their mind and decide not to take the medication.

Participating in medical aid in dying is completely voluntary for both the patient and healthcare providers. The safeguards in the legislation protect vulnerable people, and they protect the doctors who treat them.

The legislation as drafted protects people with disabilities as is evidenced by this letter from Disability Rights Oregon: “DRO has not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon’s Death with Dignity Act.” Evidencebased research also concludes that the legislation has the potential to improve hospice and palliative care, by spurring earlier conversations between doctors and patients about end-of-life care options, and leading to higher utilization of hospice and palliative care.

In addition, more than one-third of terminally ill adults in Oregon who get aid-in-dying medication do not take it. But studies show they enjoy peace of mind knowing they can take it if they need it. It enables them to enjoy their remaining time, free of worrying about suffering through an agonizing, prolonged death.

GROWING SUPPORT

Since terminally ill Californian Brittany Maynard first shared her story nationwide and advocated for medical aid in dying in October 2014, people across the country have been raising their voices in support of medical aid in dying with laws recently being enacted in California and Colorado, and awaiting passage in Washington, D.C. A groundswell of support has also been building here in Maryland.

Quite simply, constituents want this option. A bipartisan survey shows that 65% of Maryland voters support the bill with majority support across key communities including Catholics, African-Americans and Republicans.

This past year, the Maryland State Medical Society dropped its opposition and has now taken a neutral position on the legislation. The bill has also been endorsed by

organizations like the United Seniors of Maryland, the ACLU, the Unitarian Universalist Church, the Central Atlantic Conference of the United Church of Christ and the Libertarian Party of Maryland.

PALLIATIVE CARE

While palliative care and hospice programs provide extraordinary comfort to patients and work wonders for many dying people and their loved ones, there are times when even the best palliative options cannot alleviate pain and suffering. Patients may suffer from physical and emotional agony, a loss of autonomy, and an inability to engage in enjoyable activities. Only the dying person can decide whether their pain and suffering is too great to withstand the pain. This legislation puts the decision-making power where it belongs: with the dying person.

The voices of Maryland residents deserve to be heard. The time has come for state lawmakers to act on behalf of the majority of their constituents and pass the “Richard E. Israel and Roger ‘Pip’ Moyer End-of-Life Option Act” so that as we each face the inevitable end of our lives, we are offered autonomy over how we die — and the peace of mind that goes along with it.

Kim Callinan is a 20-year Maryland resident and the chief program officer at Compassion & Choices, the nation’s oldest, largest and most active national organization working to improve end-of-life care.

1. Callinan discusses how patients should have the right to die because “only the dying person can decide whether their pain and suffering is too great to withstand.” Do you believe that this statement is in agreement with the right-to-die legislation that is currently on the books in the United States and elsewhere, based on what you’ve read?

2. The author points out that, in Oregon, as many as one-third of the patients who are given prescriptions for life-ending medication don’t fill them or take the drugs. If people are not using the medication, do you think this helps or hurts the argument that they should have the right to get it?

“KEVORKIAN, LIES, AND SUICIDE: DID KEVORKIAN REALLY SEE HIS ACTIVITIES AS MEDICAL OBLIGATIONS?,” BY THOMAS S. SZASZ, FROM THE FOUNDATION FOR ECONOMIC EDUCATION, MAY 1, 2001

Jack Kevorkian became famous allegedly for helping persons commit suicide. His supporters continue to hail him as the person who put physician-assisted suicide on the political

map of America. This is a false image created by Kevorkian and the media. Webster's Dictionary defines suicide as "an act or an instance of taking one's own life voluntarily and intentionally." Strictly speaking, then, assisted suicide is an oxymoron.

This does not mean that one person may not help another kill himself by furnishing him the means to do so, for example, by selling him a rope, a gun, or a drug. We do not regard gun shop owners or pharmacists as practicing suicide assistance, and do not call killing oneself by means of these tools "assisted suicide." Similarly, we do not regard persons with access to lethal drugs who kill themselves with them, such as health-care personnel, as having committed "pharmaceutical company-assisted suicide." However, we regard persons who lack access to lethal drugs but kill themselves with such drugs made available to them by doctors as having committed "physicianassisted suicide."

The so-called problem of physician-assisted suicide thus comes down to a simple question: Why do people need the help of doctors to kill themselves with drugs? The answer is obvious: Because the trade in drugs useful for killing oneself is illegal, and anyone interested in terminating his own life with a drug needs a doctor to supply it.

Misleadingly, Kevorkian's subjects were called "patients." However, Kevorkian had no license to practice medicine and the people he "helped" did not come to him to be diagnosed or treated. His clients traveled, sometimes thousands of miles, to secure his services. If they could do that, they could have killed themselves by other means, for example by architect-assisted suicide, a.k.a. as jumping off a tall building. They came to Kevorkian, then, either to obtain lethal drugs to which they had no access but Kevorkian did, albeit illegally; or they came to die by Kevorkian's hands

rather than their own, anxious to depict medical killing as "therapy." Kevorkian was eager to oblige, portraying himself as a heroic fighter for a right to suicide.

"MEDICIDE" AND THE "MERCITRON"

In his book, *Prescription: Medicide*, Kevorkian stated that his "ultimate aim [is] not simply to help suffering or doomed persons to kill themselves—that is merely ... [a] distasteful professional obligation (now called medicide) ... What I find most satisfying is the prospect of making possible the performance of invaluable experiments or other beneficial acts." (The term "medicide" is typical Kevorkian: as germicide means killing germs, so medicide means, or ought to mean, killing medicine or killing doctors.) Explained Kevorkian:

> [N]o longer is there a need—or even an excuse— for anyone to be the direct mediator of the death of another who is alert, rational, and who for some compelling reason chooses to, or must, die. Performance of that repulsive task should now be relegated exclusively to a device like the Mercitron, which the doomed subject must activate .... [M]edicide has now been eliminated as an ethical problem for the medical profession .... The device's impact on morality extends to execution chambers as well .... Only by using the Mercitron ... [can] the execution be made even more humane .... The Mercitron can diffuse it [moral guilt] even more by eliminating entirely the need for anyone to inject anything.

To eliminate the person as a moral agent responsible for his act, the psychiatrist attributes suicide to mental illness. Similarly, to eliminate both the physician who kills and the subject who allows himself to be killed as moral agents responsible for their actions, Kevorkian attributes killing "doomed persons" to a machine he calls the Mercitron. Who makes and operates it? Kevorkian. He gets credit for his great discovery. No one is blamed for the deaths "it" causes.

KEVORKIAN ON SUICIDE

The word "suicide" refers to voluntary (noncoerced) self-killing. Kevorkian uses it to denote killings of all sorts, for example, the killing "of fetuses, infants, minor children, and every human being incapable of giving direct informed consent." Abortion, infanticide, and judicially authorized execution are, in Kevorkian's vocabulary, all instances of "suicide." Satisfied with that classification, Kevorkian concluded: "The above list of categories encompasses all potential candidates for the humane killing known as euthanasia, by others or the self."

To the press and the public, Kevorkian represented his activities as a medical obligation, imposed on him by his conscience and medical degree. But Josef Goebbels knew better, and was more honest, when he said, "We speak not in order to say something, but in order to obtain a particular effect." So Kevorkian, when asked in court, "have you ever wanted a patient to die?," replied, under oath: "Never." Calling the prosecutor "a lying psychotic," Kevorkian denied that "he has ever assisted in a suicide." Finally, to prove his sincerity, he threatened that, if convicted, he would starve himself to death: "I know they are going to force-feed me … and I'm not going to go along with it." Kevorkian's lawyer,

David Gorosh, said his client will ultimately be “lauded as a hero in history.” To make himself appear a medical savior, Kevorkian falsely diagnosed his “patients” as dying. To make himself a medical martyr, he falsely promised to die for his cause.

Eventually, Kevorkian’s luck ran out and he was sent to prison for his crimes to which he appears to have been driven by his megalomaniacal vanity. Has he killed himself by self-starvation, as he promised he would? No. Either he has changed his mind or he never meant what he said. If he changed his mind, he has availed himself of precisely that option which he denied his victims. And if he never meant what he said, then he has demonstrated the fatal unreliability of his diagnoses concerning his “patients’” alleged terminal illnesses.

Kevorkian spends his time in jail seeking freedom by filing appeals. His lawyer claims that Kevorkian “suffers from high blood pressure, always wears a sweater because he’s cold, and looks like a skeleton.” Kevorkian wore a sweater and looked like a skeleton before he entered prison and, from all we know, had high blood pressure as well.

1. The author talks about the word “suicide” and how Dr. Jack Kevorkian often used it to mean something other than chosen death at a person’s own hand. Why does the language used by Kevorkian matter?

2. The author asks a question: Why do people need a doctor’s help to kill themselves when

they could just as easily kill themselves unassisted? He then discusses the desire by some to pass off the blame onto someone else or the feeling that assisted suicide is not the same as suicide. Based on what you've read in previous chapters, do you think there is a significant difference? Explain your answer.

CHAPTER 5

WHAT THE MEDIA SAY

The media are responsible for how many people think of assisted suicide, from the words they choose to the angles they present when discussing the subject. But the media isn't always attempting to be objective, either. Op-eds and editorials allow members of the media to express their personal feelings on subjects like the right to die, and those, too, can influence how society views the issue. As you read the following articles, think about whether the pieces appear biased or have a particular idea they're promoting, and if they do, does it appear that the angle is intentional.

"EUPHEMISM AND SUBTERFUGE FOG THE PHYSICIAN ASSISTED SUICIDE MOVEMENT" BY GREG KLINE, FROM *MARYLANDREPORTER.COM,* JANUARY 27, 2016

One of the most contentious issues to be debated during this year's General Assembly session will be the renewed effort to legalize physician assisted suicide. After withdrawing a bill last year, proponents, led by Del. Shane Pendergrass, D-Howard, have renewed their efforts in this year's General Assembly session.

Proponents of physician assisted suicide often claim that they want an honest debate on this issue and insist that if people knew the true facts they would prevail. However, their entire movement is shrouded in euphemism and artifice.

We can start with the main engine driving this movement not only in Maryland, but throughout the country. An organization calling itself Compassion and Choices was formed in 2007 as the successor to the more honestly named Hemlock Society.

THE HEMLOCK SOCIETY

The Hemlock Society, named as a reference to the famed suicide of Socrates, was founded in 1980. Its founder, Derek Humphry, stated that any assistance in one's suicide should not be a crime and that alternate views of the "dying process" "must not trump the autonomy of the dying person's own decisions."

Dr. Jack Kevorkian embodied this radical view of "autonomy" and the right to suicide. After Kevorkian's public actions, in defiance of Michigan laws among others, states like Maryland affirmed their laws against assisted suicide. It is little wonder then that the current physician assisted suicide movement seeks to rebrand itself to move past its Kevorkian past.

Likewise, proponents of physician assisted suicide seek to avoid the term “suicide” itself. According to the Compassion and Choices website, what they propose is not physician assisted suicide at all even though the bill specifically allows a physician to prescribe a lethal dose of medication that a patient self-administers to end their own life. Such absurd semantics are beyond Orwellian and demonstrate the fundamental lack of candor of this movement.

FALSIFYING THE CAUSE OF DEATH

This absurd distinction is embodied in the legislation as well. In last year’s version, as in similar bills introduced throughout the nation, doctors were required to put the cause of death as something other than suicide on the death certificate. The legislation mandated that even though a patient died as a result of an overdose of medication administered by themselves to end their own lives, the doctor must put the cause of death as the underlying terminal disease with which they were diagnosed.

Such an “unsuicide” would make Orwell proud.

Even the name of the bill has been rebranded. Last year the legislation was titled the “Death with Dignity Act” and included the names of two prominent citizens, who have since passed away. This year, according to press reports, the legislation will be more euphemistically titled the “End of Life Option Act” removing any reference not only to suicide, the “end of life option” being advocated, but of death at all.

INCREASING SUICIDE RATES

And it is little wonder that proponents of physician assisted suicide want to avoid engaging the issue of suicide directly. If they did they would have to respond to inconvenient facts like the recent study of the Southern Medical Journal finding that states that legalized physician assisted suicide saw an overall increase in the rate of suicide in the adult population, independent of those seeking physician assisted suicide. This documented “suicide contagion” comes at a time when our nation has seen an increase in the national adult suicide rate from 1999 to 2010 of nearly 30%.

Proponents of physician assisted suicide also want to avoid discussing the impact on the physician patient relationship such laws create. Major medical organizations from the American Medical Association, the American College of Physicians and the American Nurses Association, oppose physician assisted suicide. Medical professionals often cite the dictates and the spirit of the Hippocratic Oath, the ancient promise made by doctors entering the profession, in their opposition.

OATH AGAINST POISONING

The oath provides, in part, that a physician will take care that their patients suffer no hurt or damage and that, “Nor shall any man’s entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so.”

Obviously, no doctor taking such an oath could prescribe a patient a lethal dose of medication with the intent to poison them to death. This breach with ancient medical ethics is why so many medical professionals and organizations oppose this legislation. It was also a major reason cited by dozens of state legislatures and the British

Parliament when these bodies overwhelmingly rejected similar legislation.

In response, Compassion and Choices claims that "Debates about the origins and relevance of the Hippocratic Oath are ongoing in the medical community." They advocate a more nuanced and "modern" view of the doctor-patient relationship in which doctors not only keep patients alive longer but help them end their lives as they wish.

RAISING SERIOUS QUESTIONS

All of this raises some serious questions. If advocates of physician assisted suicide are on the "side of the angels" and their cause is just, why must they rely upon such mendacity? If advocates truly want an honest debate in which all the facts are disclosed, why must they employ such Orwellian language? If physician assisted suicide is morally right and consistent with our culture's highest values, why does it require a rewriting of millennia old medical ethics?

Opponents of physician assisted suicide, like the honestly named Maryland Against Physician Assisted Suicide, welcome an honest debate on this issue. We welcome a true and thorough airing of all the facts in plain language and without euphemism or subterfuge. We are eager to discuss the fundamental values we want our culture to embrace.

Such an honest debate here in Maryland will result in the defeat of this measure yet again this year.

1. The author discusses how the language around assisted suicide changes how an argument is viewed. He suggests that the organization known as Compassion and Choices is in name alone sending a message that is not accurate. Based on his arguments about language, how would you choose to discuss this issue if you were a newspaper editor? What words would help you tell the story without instilling a bias?

2. The author talks about how many bills that promote assisted suicide don't use the word "suicide." Based on what you've already discussed about how language affects how we see things, why do you think this is? Should the word "suicide" be required?

"HOW 'DR DEATH' SINGLE-HANDEDLY FOUGHT FOR THE RIGHT TO DIE," BY MICHAEL DECESARE, FROM *AEON*, MAY 25, 2016

Social change usually happens slowly. It takes time for technology to advance, for social movements to generate momentum, for new policies to be developed, or for public opinion to shift. But sometimes individual activists can

create change quickly. Such was the case with DrJack Kevorkian, who single-handedly initiated a national debate over assisted suicide.

In 1990, the aid-in-dying movement in the United States was more than 50 years old and included a number of formal advocacy organisations. Yet it had failed to hold the public's attention for any sustained period of time, even with early support from the likes of Helen Keller and Jack London. That all changed in June 1990 when Kevorkian helped the Alzheimer's patient Janet Adkins end her life in the back of his Volkswagen camper. Overnight, the retired pathologist was thrust into the national spotlight. Was he a defender of dying with dignity or a cold, clinical killer?

Kevorkian conducted more than 100 assisted suicides in the 1990s, landing in four highly publicised criminal trials. That is, he spent the entire decade as a celebrity activist, one who would leave an indelible mark on the culture while sowing the seeds of social change. Terms such as *Kevorkianesque* and *Kevorkian pact* entered the lexicon. The doctor and his Mercitron, or 'suicide machine', were referenced on countless Top 10 lists on *Late Night with David Letterman*. Kurt Vonnegut published *God Bless You, Dr Kevorkian* in 1999. An award-winning 2010 biopic starred Al Pacino. A restaurant in Toronto even serves the 'Big Kevorkian', a burger that boasts a day's worth of fat and salt.

Yet many continue to minimise Kevorkian's influence on the aid-in-dying movement, dismissing him as a simple rogue activist or an attention-seeking zealot. His antics, both public and private, contributed to that characterisation, as did his penchant for leaving his patients' bodies at the coroner's office or in motel rooms. But the primary reason for observers' disregard of Kevorkian's crucial role in the aid-in-dying movement is more subtle. It's not that they disliked

him. It’s that they couldn’t categorise him. Scholars and media pundits alike tend to celebrate (or criticise) movement leaders affiliated with formal organisations – think Cesar Chavez and the National Farm Workers Association, for example, or Betty Friedan and the National Organization for Women, or Dr Martin Luther King, Jr and the Southern Christian Leadership Conference. Kevorkian, by contrast, never belonged to any aid-in-dying organisation, and his relationship to those organisations’ leaders was oppositional, to put it mildly. Operating outside of organisational constraints, he proved an enigma to those who sought to understand him or worse, control him.

Kevorkian’s role as a maverick was crucial to his success in bringing about change. Standing apart from the movement’s formal leaders enabled him to use tactics unavailable to them, since they were bound by organisational and political concerns. Kevorkian had none. Whether arriving at court in a revolutionary-era costume or publicly chiding and insulting those who opposed him – including the American Medical Association, the Catholic Church, and innumerable politicians and prosecutors – he commanded the public’s attention but answered to no one. The aid-in-dying movement’s ‘loose cannon’, as he was frequently described, was therefore able to impact the culture in a way that formal leaders and their organisations were unable to. It is doubtful that a burger will be named after the Hemlock Society in the US; no movie will be made about its founder Derek Humphry’s life.

Kevorkian’s impeccable professional credentials, his personal proclivities for publicity, and his asceticism also contributed to his success as a lone activist. He was a licensed medical doctor with an impressive record of publication in scholarly journals. The son of Armenian

immigrants, he had served in the US army, including a tour of duty in Korea in 1954-55. He rented a sparse apartment above a flower shop in Royal Oak, Michigan. In courtroom testimony and television interviews, he came off as an articulate and reasonable, if occasionally ill-tempered, grandfather figure. His selflessness was best illustrated by the fact that he never accepted payment from his patients.

It was Kevorkian's independence from aid-in-dying organisations and their leaders that enabled him to press harder than anyone else in the history of the movement – on politicians, on legal authorities, on the medical establishment, on religious opponents, and on the public. What resonated with people was pictures of Kevorkian and his 'Mercitron', it was the doctor's face on the cover of *Time* magazine, it was his hunger strikes in jail. Kevorkian's mass-mediated spectacles, much more than aid-in-dying organisations' theoretically sophisticated arguments, appealed to the public and forced the social, political and cultural change that had eluded the movement for so long.

Kevorkian's success can be clearly seen in the movement's unprecedented legislative gains and in the growing public support of aid-in-dying. Between 2008 and 2014, four states joined Oregon – where assisted suicide has been legal since 1997 – in allowing terminally ill patients to seek help in dying. This June, a law allowing aid-in-dying will take effect in California. More than a dozen other states are currently considering similar bills. With nearly 70 per cent of Americans approving of the practice, public support is at its highest level in more than a decade. In 2014, the highly publicised decision of Brittany Maynard, aged 29 with terminal brain cancer, to move from California to Oregon in order to end her life was the latest example of a roughly 25-

year national trend toward greater control over the circumstances of one's death.

Kevorkian kick-started the trend in the back of his camper on that chilly, overcast spring morning in 1990. In so doing, he reminded us of the potential power of a single, determined activist to bring about social change. There can be no doubt that 'Dr Death' still matters.

1. The author discusses how Dr. Jack Kevorkian's name became synonymous with the aid-in-dying movement and the discussion of assisted suicide. There were books and movies about him, and he was constantly in the media during his trial in the 1990s. Based on what you've read and what you know about Kevorkian's media presence already, do you think his fame impacted the way we talk about assisted suicide?

2. Do you believe that the death with dignity movement would be as widely discussed now if not for the early media coverage of Dr. Kevorkian? Using examples from the author and other articles in the book, explain your thinking.

“COLORADO’S ASSISTED-SUICIDE BILL: DEATH WITH DIGNITY OR SOMETHING ELSE?,” BY DAN RODGERS, FROM *MICHELLEMORIN.ORG*, FEBRUARY 5, 2015

On Friday February 6, 2015, the State of Colorado will debate within the House Committee on Public Health Care and Human Services the merits of state approved suicide. ~~HB15-1035~~ HB15-1135 is titled, “Death with Dignity”, but is it really is a phrase to hide a darker reality.

Legislators will hear testimony solicited by the proponents of state sanctioned suicide, heart wrenching stories of loved ones who suffered horribly until death eased their pain. The bill’s proponents will argue for Colorado to be compassionate in allowing a terminally ill person to end their life so their suffering, along with the burden on families left to care for the their family member, may be eased by the state providing the means of death.

On the other side, we will hear equally heart wrenching testimony, but at the same time *inspiring* stories of loved ones who have suffered and endured unimaginable pain, but who have also received the miracle of either recovery or revelations at the very end which changed their lives and the lives of those left behind forever.

Many will argue it is an individual choice to take their own lives. Others will show our lives are not our own to take.

On Friday, members of the committee will take the first steps in deciding whether or not it is the function of Colorado government to provide a path to death. If they agree that the government’s role is sanctioning a means to

suicide, they will likely make those decisions without hearing the truth of what is really behind this effort: money and the new paradigm shift in American healthcare from *quality of care* to that of *cutting the cost of care*.

IS THIS BILL A CONCERTED, MULTI-STATE EFFORT?

If this really is just a "Colorado" effort brought forward by *our* legislators at the behest of Colorado families (as we *are* a compassionate people), then how is it that just two weeks ago nine Democrat members of the Iowa legislature introduced an identical bill HF 65? Other than the formatting differences between the two states' legislatures, Iowa's HF65 is a bill legalizing Physician-assisted Suicide with wording *identical* to Colorado HB15-1035. It is pure "cut and paste".

All across the country we see the same bills advocating for exactly the same thing. How can different states have exactly the same language in state bills and laws on an issue supposedly based on individual states versions of "compassion"? The reality is darker, and if we are willing to be honest, compassion has little to do with it.

THE DESIGNERS OF GOVERNMENT HEALTH CARE *MUST* INCORPORATE STATE-ASSISTED SUICIDE TO KEEP COSTS MANAGEABLE.

In 2010, soon after the now proven less-than-Affordable Care Act was forced upon America, Dr. Elizabeth Wickham,

Ph.D. wrote in "*Repackaging Death as Life-The Third Path To Imposed Death*":

> *We are ata critical juncture in health care as funding moves from private to public sources. For "third path" proponents, end-of-life care has always included making ends meet within a nationalized health care system. It would appear that this new version of palliative care may be emerging as the "glue" that holds our reformed health care together."*

Upon what basis is Wickham drawing this critical junction between healthcare and state-approved suicide? She continues:

> *Prior to the passage of the national health care legislation, the unanswered question for the "third path" people had been, "If we build a field ofpalliative care, will anyone come?" How to convince the American public to accept the curtailment of services? Listen carefully nowas theyuse the marketing technique of selling value. But it will be value based on quality, and quality measured in costcontainment*.

When Obamacare passed and changed the meaning of healthcare in America forever, Dr. Wickham named the "leaders" in the government's drive to contain cost in government controlled healthcare. One of them was Don Berwick, head of the Centers for Medicare and Medicaid (CMS), who was famous for saying that we will go into "rationing with our eyes open."

Prior to being tapped to head CMS, Berwick was the president and CEO of the International Institute for Healthcare Improvement (IHI). Dr. Wickham explains the goals of IHI:

"IHI focused on end-of-life care from the start. It specializes in bringing together health care organizations to produce guidelines. Their Collaborative on End-of-Life Care which set forth three objectives:

1) *Institute advance care planning discussions within 24 hours of hospital admission and document the plan in a patient's chart*.

2) *Reduce the number of transfers to the hospital in the last 2 weeks of life and reduce emergency room utilization*.

3) *Begin bereavement assistance and support for the family and friends before a patient's death*.

Mr. Berwick was also co-chair of the National Priorities Partnership. Its mission? To identify palliative care and end-of-life care as one of the top five priorities for "improvement" in nationalized healthcare.

Mr. Berwick tapped Joanne Lynn head his IHI End of Life Care effort. Lynn stated in 2008:

"We need to build a social consensus drawing on a new paradigm that tailors care to the new reality of dying—which is after a long, chronic illness. Not only is it the right thing to do, it makes good business sense."

WHERE WILL THIS GO IF COLORADO CONSENTS TO STATE SPONSORED KILLING OF "TERMINALLY ILL" ADULTS?

Look no further than Belgium which now, in the name of "compassion," allows doctors to euthanize ill children. This is not a slippery slope; it is off a cliff. Like Iowa's bill, and like other bills and laws providing for state approved suicide around the country, insurance companies are forced to pay life insurance payouts to surviving beneficiaries.

Fair, some will argue, as the death of the individual is likely; however, it is not for certain. Miracles occur. Who will say with certainty that people will not be pressured to see their life end before they are ready, by a system which offers a way to end the burden on their family? Families will now be provided for financially.

Berwick was a key player during Obamacare's implementation. Notice his stated #1 goal, from above: "Institute advance care planning discussions within 24 hours of hospital admission and document the plan in a patient's chart".

Remember the outrage as the Veterans Administration instituted mandatory end of life counseling in 2010, and then the horror as hundreds of American died while the VA withheld care through secret "waiting lists." Money saved.

DON'T BE FOOLED BY THE COMPASSION PLOY. STATE-ASSISTED SUICIDE IS ABOUT MONEY.

In reality, it is the cost of treating the terminally or long term care patients which is really driving this effort, *not* compassion and *not* the dignity of the patient. It is about "good business sense."

Colorado legislators will hear many heart wrenching stories on Friday, but they will likely hear very little about the darker side of this pathway to stateapproved death.

1. Rodgers has a very different opinion on the assisted suicide issue than the other authors in this chapter, yet he still focuses on language. How is his discussion of language different from the other authors'? In what ways is it the same?

"LEGISLATING DEATH WITH DIGNITY NEEDS DEBATE WITH DIGNITY," BY MICHAEL COLLINS, FROM *MARYLANDREPORTER.COM,* FEBRUARY 13, 2017

The introduction again of legislation that would allow people with terminal illnesses to obtain lethal doses of drugs with which to kill themselves has reignited the debate about assisted suicide in Maryland.

The attraction of the "Richard E. Israel and Roger "Pip" Moyer Death End-of-Life Option Act," HB370 and SB354, is understandable. Who has seen people in the last stages of a terminal illness and not thought, "What can we do to ease their suffering?" Whose heart has not gone out to families whose loved ones endure often intense pain as they die?

I'm sure many people have thought, "If I am ever in that condition, I don't know how long I'd want to hang on."

These laws' advocates often use intensely personal tales, such as that of former Annapolis Alderman Dick Israel, who succumbed to Parkinson's disease, and, Brittany

Maynard, a 29-year-old California woman with terminal brain cancer, who moved to Oregon to take advantage of that state's assisted-suicide law.

Yet, that the passage of these laws relies so heavily on their raw emotional appeal should make us pause. We need to ask some hard questions about these issues and think just as hard about their potentially ugly answers.

Have we exhausted all options related to palliative care? If there are laws and regulations that onerously restrict physicians from prescribing the painkillers that can alleviate a terminal patient's suffering, shouldn't we change them first?

If enacted, this law will establish the principle that people in Maryland have a right to "death with dignity," as the legislation was called when first introduced two years ago. With that accomplished, what is there to prevent the law from expanding to allow physician-administered suicide?

SLIPPERY SLOPE

In the Netherlands, where euthanasia has been legal since 2002, physicians are helping people with treatable mental illnesses—like depression—commit suicide. And, numerous doctors have become "angels of death," euthanizing terminally ill patients without their consent.

A 2012 paper by J. Pereira in *Current Oncology*, found that despite safeguards built into so-called "death with dignity" laws, most safeguards are ignored.

For example, in 2005, more than 540 people in Holland were euthanized without providing explicit consent. In the Flemish part of Belgium, 208 people were euthanized without consent because they were in a coma.

Pereira's study concluded that in 30 years, the Netherlands has slowly moved from euthanasia for terminal illnesses to euthanasia for psychological distress. That point was driven home last year in a widely reported case where a woman in her 20s—who did not have a terminal illness—was euthanized in Holland. She had been a victim of sexual trauma and her psychiatrist determined that she had untreatable Posttraumatic Stress Disorder.

LAWSUITS

Proponents of so-called "death with dignity" argue a patient should have the right to self-administer a lethal dose of prescription drugs. But what about people with disabilities? Such a law is one lawsuit from being an Americans With Disabilities Act (ADA) violation for those who cannot self-administer.

Opponents of capital punishment point to the Hippocratic Oath to keep doctors from assisting in legal executions. They have also attacked drug companies for providing the lethal cocktails for executions. And they have pointed to botched executions as reason to end all executions.

- Would doctors who prescribe lethal doses of drugs be violating their Hippocratic Oath? Could they be subject to professional sanctions?
- Will drug companies have an incentive to create more powerful poisons so a patient does not have to swallow 100 capsules?
- If even medically supervised executions can be botched, what can we assume about patient suicide? If not supervised, what happens? Could a patient be in a

permanent vegetative state requiring life support? If supervised, would more active measures be required?

Proponents of such abortion-inducing drugs as Plan-B have sued pharmacists who refuse to dispense abortificients because it violates their conscience. Will pharmacists be liable to lawsuits if they refuse to prescribe life-ending drugs?

CONSCIENCE

The introduction of euthanasia will place Maryland's health-care professionals on a collision course with numerous ethical and moral dilemmas. Anti-capital punishment activists argue that the Hippocratic Oath prohibits doctors from assisting with legal executions. Can it be made to square with euthanasia?

What about those with religious objections? Will a Muslim doctor be able to refuse to write a prescription for lethal drugs based on his religious beliefs? Will a pharmacist who is an evangelical Protestant be able to refuse to fill such a prescription on the same grounds?

GRIM EFFICIENCY?

In 2008, Barbara Wagner and Randy Stroop were denied further cancer treatments by Oregon's state-run Medicaid program because their cancers were in advanced stages. They were informed, however, that it would pay for their assisted suicide drugs.

Opponents of Oregon's assisted suicide have noted potential conflicts of interest between doctors who approve

assisted suicide and their employment with health maintenance organizations (HMOs).

Will Maryland's Medicaid provide suicide drugs? What about insurance policies purchased through Maryland's health exchange? Will we create a two-tier system where the wealthy with private insurance get their expensive cancer treatment while the poor on Medicaid get offered suicide drugs?

I fear that many of the people now holding out the promise of "death with dignity" are exploiting our compassion, anxieties, and fears in order to move us—incrementally, at first—toward a truly nightmarish future in which human life will be easily and callously disposed of in service to some amorphous "greater good." Will we soon have ambulatory "dignity" clinics, like the dystopian future presented in the 1970s film "Soylent Green?" Recall how the Edward G. Robinson character "went home," a euphemism for assisted suicide.

Before we pass the "End-of-Life Option Act" law, we need a debate with dignity, that strips away the euphemisms, asks the hard questions and gets the unvarnished answers.

1. The author raises a question about how people with disabilities would benefit, or not, under death with dignity laws, since they may be unable to self-administer the lethal drugs. How could the law take these citizens' rights into account without having to rewrite the laws to allow doctors to administer the drugs? Do you think there should be such a

provision to allow help to those who can't administer the drugs themselves?

2. The author worries that permitting assisted suicide is a slippery slope toward a world in which human life has no value. Based on what you've read from both sides, do you agree with him?

CHAPTER 6

WHAT ORDINARY PEOPLE SAY

While assisted suicide is a topic of discussion in courtrooms, legislative buildings, and newspapers across the country, it's also being talked about in our homes and schools — you're talking about it right now. But are the discussions happening in our classrooms and around our dining-room tables the same as the ones being had in public forums? As you read the articles in this section, each written by someone like you or your teacher, think about what parts of their arguments come from what you've read in other chapters and what elements of their articles are completely unique to them.

"A DYING MAN'S LAST WISH: CHANGE OUR LAWS," BY PAT LAMARCHE,

FROM *COMMON DREAMS*, APRIL 16, 2012

The majority of U.S. states make it illegal for anyone to take their own life or receive assistance in taking their own life. More than 30 of these states have laws on the books specifically identifying assisted suicide as a crime. A number of states address the concept of assisted suicide in the common law classifications while one state -- Montana -- has had the criminalization of physician assisted suicide nullified in court.

There are only two states -- Oregon and Washington -- that have specifically legalized physician assisted suicide. There, residents who are terminally ill and doomed to a horrific death would seemingly have the best possible outcome for their otherwise tragic situation.

But -- like many well intended laws passed across the U.S. -- the effective reality of physician assisted suicide falls far from its intended mark. Curtis Johnson, a 55-year-old business man and educator who suffers from Amyotrophic Lateral Sclerosis otherwise known as ALS, finds that even though he lives in Washington he cannot get the assistance he needs to end his suffering when the time comes.

ALS rarely kills someone in less than a year. Tragically, in Johnson's case, the disease has progressed so rapidly that within a few months of his diagnosis he faced the dilemma of picking when he will die. He could have much more time to live if the law did not require him to administer the lethal drugs himself. If Washington State allowed a physician to physically assist his suicide, Johnson could wait until long after his hands stopped working to end his life.

This week Johnson penned a "Final Essay" for his family and friends. He wrote that the "lack of any real assistance"

means he won’t be able to hang on between when he loses the motor skills necessary to take his life and when he actually needs a merciful end to his suffering.

Johnson must die prematurely in order to control his death at all.

Johnson explains, “although our state has a Death With Dignity law, the assistance provision in the law is a farce, only providing for a lethal prescription which must be self-administered, leaving the patient such as myself with the unenviable choice of ending their lives prematurely or crossing that threshold where they won’t be able to at all and damning them to an end of frustration and dependence, misery, pain and pain killers.” Johnson goes on, “Left with such a choice I must go with prematurely ending my life.”

Once Johnson accepted that he would die by his own hand and not when he was ready to succumb to his condition, he searched for a silver lining to the loss he, his wife, children, grandchildren and other loved ones would endure. But all he discovered was further proof of “how primitive we remain as a species.”

Johnson wanted to make the best of his death by helping others live. Johnson’s essay explains, “Although my motor neurons are wasted, only my muscle tissue is affected. Otherwise I’m a perfectly healthy 55-year old male. I don’t smoke. I exercised daily. My BP is still 110/70, and my heart rate a steady 70. My cholesterol has been as low as 128, and last stood at 160. Triglycerides and blood sugar levels have always been normal. My BMI has never been higher than 27, and body fat less than 22%.” Consequently, “I have perfectly functioning lungs, kidneys, heart, and liver.” Johnson concluded, “Surely there are candidates out there, some having waited for years, others desperately

running out of time, who could use my organs to save their own lives."

The U.S. Department of Health and Human Services says that people with infectious diseases cannot donate their organs. Those diseases are "HIV, actively spreading brain cancer, and certain severe, current infections."

But Johnson's correct, even though he doesn't have any of those donor disqualifying conditions he still cannot donate his organs when he terminates his life. Subsequently, on the day Johnson dies, 18 other people will die waiting for an organ donation that will never come.

Johnson expresses the final contemptible frustration resulting from his premature death: "When I asked physicians, social workers, and hospice professionals about donating organs I was met with ignorance and negative responses." After researching the topic himself, Johnson learned, "Organ donation must be conducted in a hospital immediately following the death of the donor. You have to be brain-dead in the hospital. Then they keep you on life support while they harvest the organs. Euthanasia is not allowed in hospitals; ergo my healthy organs get flushed."

Johnson will die soon. He'll die sooner than he needs to or wants to so that no one who loves him will be tempted to help him take the lethal dose of medicine his physician has prescribed, and his potentially lifesaving organs will die with him.

1. The author discusses Johnson's need to die sooner than he'd like because of the way the right-to-die laws work (the patient must be able to administer the lethal dose of medicine

themselves). Both the author and Johnson believe this rule is unfair to the dying patient. Based on what you've read from experts, do you think there could ever be a right-to-die law that allowed for fully assisted suicide?

2. The author also discusses how the laws currently on the books at the time of Johnson's chosen death would not allow him to donate his organs because assisted suicide, referred to here as euthanasia, is not allowed in hospitals, but he would need to die in a hospital in order to donate his healthy organs. If you were going to write a new death-with-dignity law, how would you incorporate Johnson's desires with what the experts in Chapter One believe works best?

"AID TO DYING: WHAT JAINISM – ONE OF INDIA'S OLDEST RELIGIONS – TEACHES US," BY CHRISTOPHER KEY CHAPPLE, FROM *THE CONVERSATION,* JUNE 10, 2016

On June 9, a law allowing patients with terminal illnesses to end their lives with help from a physician came into effect in California, opening conversations about whether human life

should be prolonged against the desire to die peacefully and with dignity.

A similar yet different conversation has been taking place in India for the past several years, but in reverse.

In one of India's religious traditions, Jainism, those at the end of life can choose to embrace a final fast transition from one body to another. However, a recent court case has challenged the constitutionality of this practice. As an expert in the religions of India and a frequent visitor, I have been following this issue with keen interest.

A RITE TO FINAL PASSAGE

While on a visit to a Jain university in Ladnun, Rajasthan in western India in 1989, I had an opportunity to observe the practice of "Sallekhana" or "Santhara," a somber rite through which one fasts to death.

A group of enthusiastic nuns rushed me in for a blessing being imparted to an octogenarian nun, Sadhvi Kesharji, who had taken this vow 28 days earlier. The nun had been diagnosed with a fatal kidney disease and been treated, but to no avail.

It was an auspicious moment. Her spiritual preceptor, Acharya Tulsi, praised her six decades as a nun and noted the lightness of her spirit and the strength of her resolve which guaranteed safe passage into her next incarnation.

She passed away 12 days later, in a prayerful state.

This is not the only such case. It is estimated that some 200 Jains, both lay and monastic, complete the final fast each year. Jains living elsewhere in the world observe the practice as well.

For example, two Jain women who were born in India but spent most of their adult lives in the United States chose

to fast in the last days prior to death. Vijay Bhade, a Jain woman from West Virginia, entered a fast unto death in 1997. A more recent case was Bhagwati Gada, from Texas, who suffered from advanced stage cancer and decided to fast unto death in 2013, after going through multiple rounds of chemotherapy.

WHO ARE THE JAINS?

Jainism arose more than 2,800 years ago in northeast India. It teaches a doctrine proclaiming the existence of countless eternal souls who, due to their actions or karma, bind themselves to repeated lifetimes.

These souls could manifest as elemental beings in the earth or water or fire or air. They could evolve to become micro-organisms and plants or eventually take forms as worms, insects, birds, reptiles or mammals.

By committing acts of goodness, they might take human form and ascend to a place of everlasting freedom at the highest limits of the universe, from which they continue to observe forever the repeated rounds of existence experienced by the many souls below.

Jains do not believe in a creator God or an external controller. All experiences, good and bad, are due to one's own exertions. The key to spiritual ascent resides in the performance of five vows also shared by Yogis and Buddhists in India: nonviolence, truthfulness, not stealing, celibacy and nonpossession.

Jains believe the practice of these vows helps release fettering karmas that impede the energy, consciousness and bliss of the soul. Every ethical success lightens the soul of its karmic burden. Mohandas Gandhi, the well-known leader of India's independence, who grew up in the company of Jains,

employed these vows personally and as a collective strategy of nonviolence to help India overcome the shackles of British colonization.

FREEDOM YES, BUT CAN THERE BE COERCION?

Up until recent years, the fast unto death process has been celebrated with newspaper announcements that laud the monks, nuns, laymen and laywomen who undergo this vow. But of late, questions are being raised whether it can result in coercion and cruelty.

In 2006, a young lawyer in Rajasthan, Nikhil Soni, challenged the constitutionality of this act, stating that it violates the anti-suicide laws that had been in put place by the British to stop the immolation of widows on their husband's funeral pyre. The practice of widow burning has endured, despite many efforts to abolish the practice.

The high court of Rajasthan ruled in favor of Soni in 2015, effectively making the practice of fasting to death punishable by law. However, some weeks later, the Supreme Court of India placed a stay on this ruling. The case is still awaiting its final verdict. Observant Jains claim this is an important part of their faith.

Entering the fast requires counsel and permission from one's spiritual advisor. And the process of rejection of food is gradual. First, one takes some yogurt, then only milk, then only juice, eventually moving from water to total rejection of any nutrition or hydration.

Physicians state that this is not death by starvation but by dehydration. The body automatically goes into a state of ketosis (when the body starts to break down stored fat for energy), often accompanied by a peaceful state.

RIGHTS VERSUS RITES APPROACH

What can we learn from such spiritual practices?

Debates on end of life focus on the “rights” approach, thus appealing to the rational mind. Spiritual traditions on the other hand assert that it makes no sense to prolong suffering. They use a “rites” approach to the inevitable passing of the human body.

Jains believe that the soul has always been here, that the soul cannot be destroyed and that through the process of death, one transitions to a new body.

The Jain tradition shows how we can move without attachment into death rather than clinging to life. In their acceptance of the inevitable, they set an example that death is not an evil but an opportunity to reflect on a life well-lived and look forward to what lies ahead.

1. While the Jains in the article are not assisted in their suicides, what they are doing is suicide, and their right to die is a topic being discussed in India’s courts. Based on what you’ve read in this article, do you think the Jains should have the right to die as they choose if they are not seeking assistance in death? More broadly, do you think the Indian government has the right to make suicide a crime?

2. Suicide is a choice that people often make out of desperation, as you’ve read in this as well

as other articles in the book. With that in mind, do you think the government and the courts have an obligation to determine how people can die? Explain using examples from the book.

CONCLUSION

As you've learned, assisted suicide is an incredibly complex topic that has no simple answers no matter which side of the debate you fall on. Some believe that allowing people to die on their terms is allowing them to put their own value on their lives, while others believe that allowing assisted suicide means devaluing all human life. There are those who believe that only terminally ill patients should have the right to die and others who believe everyone should have the right. Some people want fully assisted suicide with death administered by medical professionals, while some people insist that the patient must be able to administer the lethal drugs themselves. People use religion, morals, ethics, and laws to explain their positions, but it's rarely just one of those things that has helped a person form their opinion. Whichever side of the debate you fall on, it's not a cut-and-dry situation. But by using all of the lessons from the authors in this collection, you'll be able to better have an informed and educated discussion on this important issue.

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CHAPTER NOTES

CHAPTER 1: WHAT THE EXPERTS SAY

"GUIDELINES FOR PHYSICIAN-ASSISTED SUICIDE" BY RAPHAEL COHEN-ALMAGOR

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CHAPTER 2: WHAT THE GOVERNMENT AND POLITICIANS SAY

"MEDICAL ASSISTANCE IN DYING: LESSONS FOR AUSTRALIA FROM CANADA" BY JOCELYN DOWNIE

Editor's note: Due to the length of these endnotes, please find references with the original article.

CHAPTER 3: WHAT THE COURTS SAY

"THE SUPREME COURT OF CANADA RULING IN *CARTER V. CANADA:* A NEW ERA OF END-OF-LIFE CARE FOR CANADIANS" BY HADI KARSOHO

[1] The courts in Montana and New Mexico decriminalized physician-assisted suicide in 2009 and 2014 respectively; however, these decisions were based on state constitutions and their effects are thus limited to those jurisdictions.
[2] Section 241(b) prohibits anyone from aiding and abetting another person's suicide.
[3] Section 14 prohibits anyone from consenting to their own death.

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BOUVIA V. SUPERIOR COURT BY JUDGE J. BEACH

[1] At oral argument in this matter, counsel for petitioner advised us that it was his belief if petitioner received the relief which she requested by her petition for preliminary injunction, i.e., the removal of the tube and prohibition of the use of other similar apparatus unless consented to by her, she would not pursue this lawsuit further.

[2] Her instructions were dictated to her lawyers, written by them and signed by her by means of her making a feeble “x” on the paper with a pen which she held in her mouth.

GLOSSARY

assisted suicide—When a person commits suicide with assistance from another party, such as a doctor or nurse. It is generally considered an option only for terminally ill people who will be dying soon regardless of suicidal ideation.

death with dignity—The idea that people should be allowed to die in a fashion of their own choosing and should not have to suffer through having their mind and body ravaged by terminal illness.

depression—A medical condition in which some people's brains do not produce enough serotonin (a feel-good chemical) and they feel sad, unmotivated, or feel nothing at all. People who suffer from depression are more likely to commit suicide even when they are not terminally ill.

euthanasia—Another word for assisted suicide. In many instances "euthanasia" is viewed as a negative term while "assisted suicide" is seen as a more neutral choice.

faculties—Another term for thoughts; most medical ethicists demand that patients have all their "faculties" about them— or be thinking clearly— before they can be considered for assisted suicide.

hospice—A home that takes care of patients who are typically terminally ill.

palliative care—Medical care focused on providing pain relief, rather than addressing the underlying cause. This type of medical care is often provided in the case of terminal illness.

physician—A doctor.

physician-assisted suicide—Suicide that is aided by a doctor, typically through the prescription of a lethal dose of medication.

quality of life—How comfortably people can live, both in terms of their external life, like their home and surroundings, and in terms of their internal life, like their mental and physical health. Assisted suicide is often described as a way to let people die while their quality of life is still high.

right-to-die—Pertaining to the belief that people have the right to refuse medical care that may prolong their care in the case of terminal illness.

right-to-life—Pertaining to the belief that people should not have the legal right to refuse medical care that may cut their life short.

sound mind—In legal terms, having the capacity to think and reason for oneself.

suicide —The intentional and voluntary ending of one's own life.

terminal illness—An incurable disease that cannot be treated and will presumably lead to death.

FURTHER READING

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WEBSITES

The Brittany Maynard Fund
www.thebrittanyfund.org
This organization forms part of the Compassion & Choices organization, which advocates for death-with-dignity laws across the country and fights for the death rights of those in states without assisted suicide laws. Brittany Maynard fought for her own right to die in 2014, as well as the rights of other terminally ill patients who wished to take control of their end-of-life situations.

Death With Dignity
www.deathwithdignity.org
This advocacy group promotes death-with-dignity and right-to-die laws across the United States. The group provides information and education on assisted suicide and aids government leaders who wish to introduce death-with-dignity bills in their jurisdictions.

INDEX

A

AB v. Canada, 91
Acta Bioethica, 41–63
active euthanasia, definition of, 164
Adkins, Janet, 184
Advances in Medical Ethics, 14–36
Aeon, 183–187
Affordable Care Act (Obamacare), 189, 190, 192
aid-in-dying laws, and class differences in medical care access, 37–41
Alzheimer's disease, 94, 184
American Medical Association (AMA), 28, 29, 150, 181, 185
American Medical Association Code of Medical Ethics, 111
Americans With Disabilities Act (ADA), 195
amyotrophic lateral sclerosis (ALS), 59–60, 61, 76, 80, 92, 110, 199
"argument from autonomy," 15–16
Aquinas, Thomas, 42
assisted suicide, explanation of, 67
Australia, assisted suicide legislation in, 9–13, 24, 26, 76, 102

B

Barber v. Superior Court, 143, 144, 146, 147, 148, 149, 152, 157
Bartling v. Superior Court, 143, 144, 145-146, 147, 149, 150, 151, 152, 156, 157
Belgium, assisted suicide in, 11, 13, 14, 24, 28, 30, 99, 105, 191, 194
Berwick, Don, 190, 191, 192
Bioéthique Online, 110–115
Bolthouse, Bill, 72–73, 74 *Bouvia v. Superior Court,* 138–161
British Voluntary Euthanasia Society, 52

C

California, assisted suicide legislation in, 37, 65, 68, 69, 73, 102–108, 138-161, 169, 171, 186, 203
California End-of-Life Option Act (EOLA), 37, 38, 103
California Natural Death Act, 144, 147, 148
Callinan, Kim, 168–173
Canada, assisted suicide legislation in, 76–102, 110–115
Canadian Bioethics Society, 114–115
Canadian Charter of Rights and Freedoms, 77, 81, 82, 91, 92, 93, 96, 110, 111
cancer, 20, 73, 94, 105, 122, 166, 187, 193, 196, 201, 204
Canon Law, 42
Carroll, Cory, 74
Carter v. Canada, 80, 82, 84, 85, 92, 95, 96, 110–115
Categorical Imperative, 17
Catholic Church, 67, 71–72, 163, 185
Catholic Health Initiatives, 72
Chapple, Christopher Key, 203–207
chloral hydrate, 68
chronic obstructive pulmonary disease (COPD), 92
Coalition of Compassionate Care of California, 40
Cobbs v. Grant, 143, 144, 146
Cohen-Almagor, Raphael, 14–36
Collins, Michael, 193–197
Colorado, assisted suicide legislation in, 65–75, 169, 171, 188–192
Colorado Hospital Association, 70, 71
Colorado Independent, 65–75
Common Dreams, 199–202
Compassion & Choices, 40, 65, 66, 67, 69, 70, 179, 180, 182, 183
Conversation, 9–13, 37–41, 102–108, 163–168, 203–207
Coumbias, Betty, 56–59, 63
Coumbias, George, 56–59, 63
Croatian Medical Chamber's Code of Medical Ethics and Deontology, 22–23
Cruzan by Cruzan V. Director, Missouri Department of Health, 116–138

D

Decesare, Michael, 183–187
dehydration, 94, 206
de Moor, Simona, 11, 12
Denton, Andrew, 9, 10

Devine, Philip, 45, 46
Dignitas, 44, 54, 56, 58, 59, 60, 63, 110
Disability Rights Oregon, 170
District of Columbia, 37, 171
Doctors with the End of Life, 68
Downie, Jocelyn, 76–102

E

England, 12, 14, 42
Epictetus, 50
Ethical and Religious Directives for Catholic Health Care Services, 71
euthanasia, explanation of, 67
Ewart, Craig, 59–62

F

Foundation for Economic Education, 173–177
Fourteenth Amendment (Due Process Clause), 128, 129, 131, 132, 137

H

Hemlock Society, 179, 185
Hickenlooper, John, 65, 67
Hippocratic Oath, 57, 73, 160, 163, 181–182, 195, 196
Humphry, Derek, 179, 185
Huntington’s disease, 92, 94

I

India, suicide in, 203–207
Israel, 14, 32

J

Jainism, and tradition of suicide by starvation, 203–207
Jean Truchon and Nicole Gladu v. Attorney General (Canada) and Attorney General (Quebec), 93
John Paul II, Pope, 43
Johnson, Curtis, 199–201, 202

K

Kant, Immanuel, 16–17, 18

Karsoho, Hadi, 110–115
Kevorkian, Jack, 6, 64, 173–177, 180, 184–187
Kline, Greg, 179–183

L

LaMarche, Pat, 199–202
Lamb v. Canada, 93
Lynn, Joanne, 191

M

Manelli, Ludwig, 58
Maryland, assisted suicide legislation in, 168–173, 179–183, 193–197
Maryland Against Physician Assisted Suicide, 182
Marylandreporter. com, 168–173, 179–183, 193–197
Maynard, Brittany, 171, 187, 193
McGee, Andrew, 9–13
medical-aid-in-dying, explanation of, 67
Mercitron, 175, 184, 186
MichelleMorin.org, 188–192
Michigan, 180
Missouri, 116–138
Montana, assisted suicide legislation in, 103, 104, 105, 169, 199
morphine sulfate, 68
Motto, Jerome, 49, 50, 58
multiple sclerosis, 92, 94

N

Nembutal, 68
Netherlands, assisted suicide in14, 20, 21, 23, 30, 99, 105, 107, 194
Nicklinson, Tony, 12, 13

O

Oregon, assisted suicide legislation in, 38, 65, 103, 104, 105, 106, 107, 169, 172, 186, 187, 193, 196, 199
Oregon Death with Dignity Act, 24, 26, 28, 170
Orentlicher, David, 102–108

P

palliative care, 14, 70, 78, 79, 83, 87, 89, 165, 170, 171-172, 190, 191, 193
Parkinson's disease, 92, 193
passive euthanasia, definition of, 164
pentobarbital, 68, 98
phenobarbital, 68
physician-assisted suicide, guidelines for and explanation of, 14–36, 111–112
Prescription: Medicide, 174
Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, 148–149
Proposition 106 (Colorado), 65, 67

Q

Quebec Select Committee on Dying with Dignity, 96
QUT Law Review, 76–102

R

Rawls, John, 18
Ray, Kelsey, 65–75
religion, and correlation between race and opinion of euthanasia, 38–39
"Repackaging Death as Life — The Third Path to Imposed Death," 189–190
"respect for others" argument, 16–21
Richard E. Israel and Roger "Pip" Moyer End-of-Life Option Act, 168, 193
Rodgers, Dan, 188–192
Rodriguez, Sue, 76, 77, 81

S

Sallekhana, 203
Santhara, 203
Seconal, 68
Special Senate Committee on Euthanasia and Assisted Suicide, 77
starvation, 154, 159, 176, 206
Stoicism, 41–63
Suicide Tourist, The, 56
Switzerland, assisted suicide in, 56, 60, 80, 110
Szasz, Thomas, 173–177

T

Tomasini, Florence, 41–63
Tutu, Desmond, 163

V

Valeant Pharmaceuticals, 68
Van Niekerk, Anton, 163–168
Vermont, assisted suicide legislation in, 65, 103, 104, 105, 106, 169
voluntary active euthanasia (VAE), explanation of, 163, 164

W

Washington, assisted suicide legislation in, 38, 65, 103, 105, 106, 169, 19
Weinberg, Jill D., 37–41
West, Kat, 65, 66, 67, 69, 70
Wickham, Elizabeth, 189–190

ABOUT THE EDITOR

Jennifer Peters is a writer and editor based in Washington, DC. She has written about relationships, politics, defense, the military, books and the media for such outlets as VICE News, Task & Purpose, and *News & Tech.* She has written books about addiction, pop culture, and the government and has edited titles on sports, politics, and the media, including a series on the Islamic State. She always carries a book with her, even when she knows she won't have time to read it.

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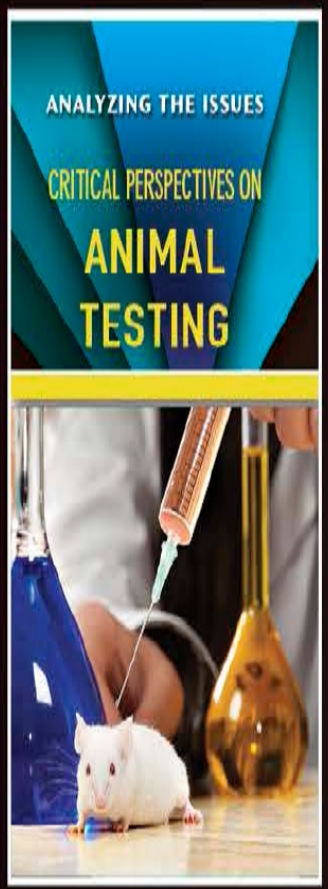

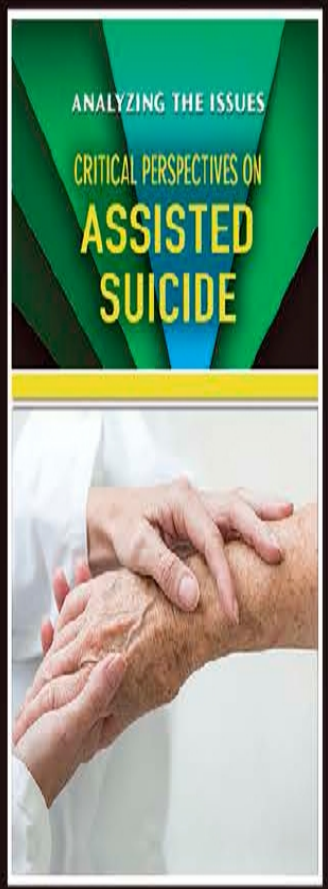

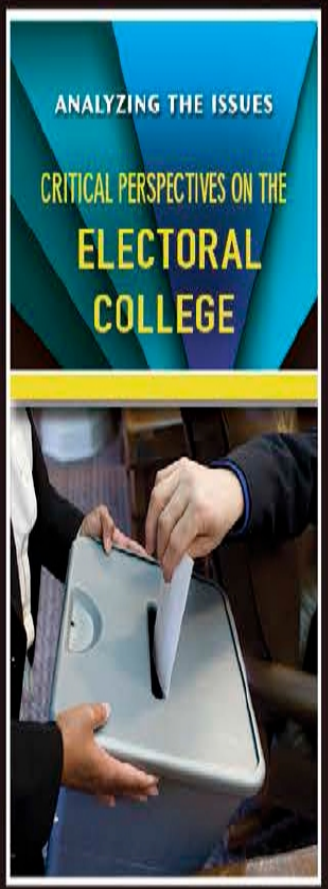

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